MEDICAL ECONOMICS

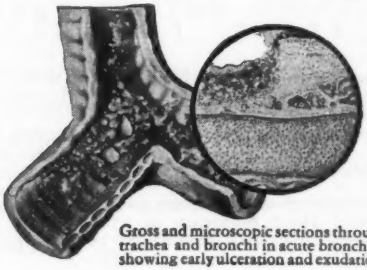
DECEMBER, 1937

MEDICAL ECONOMICS

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

CONTENTS FOR DECEMBER, 1937

DISARMING BRONCHITIS



Gross and microscopic sections through trachea and bronchi in acute bronchitis showing early ulceration and exudation.

As every physician knows, the onset of bronchitis not only is in itself serious, but its sequelae may be far-reaching and often disastrous . . . ● To abort the condition, a thick, hot

Antiphlogistine

dressing over the throat and chest is frequently *most effective.* Its long-retained heat, hygroscopic and therapeutic qualities may alter the course of the condition and be the means of completely disarming the bronchial attack.

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☆ SPEAKING FRANKLY ☆

TELEPHONE

TO THE EDITORS: Thank you for the September article by Dr. Eugene Blake, of Paris, Ky.

I, too, was overcharged for two years by the telephone company. So, like Dr. Blake, I brought the matter to the attention of our local public utility commission.

Several days later, a local representative called and presented me with a refund check for $53. He said that my rate in the future would be reduced nearly half.

The moral of this story is, obviously: *Read* MEDICAL ECONOMICS!

Ernest H. Dengler, M.D.
Pottstown, Pa.

GAMBLER

TO THE EDITORS: This letter refers to the article, "Overstuffed," in your September issue.

Since the physician who wrote the narrative got so little out of his internship, why didn't he find out about the service in the hospital he went to before signing up with it?

A year of your life at the age of 26 or 27 is too valuable to gamble with. A trip to the institution or even a letter to the resident would have set this man straight about the proposition.

I have just finished a residency in medicine in a 550-bed hospital. The best insurance, in my opinion, is to see the place you expect to intern in, talk to the house staff in person, and then decide if the institution is in a position to give you what you want.

I had an opportunity to intern in several hospitals that are much better known than the one I chose. But I found that I'd be little more than a glorified orderly if I went with any of them, so I turned them down.

If medical students took the trouble to look for *good* hospitals during their senior year, institutions of the type mentioned in your article would soon have to change their set-up in order to get interns.

M.D., Michigan

PROTEST

TO THE EDITORS: Dr. Baketel's editorial in the October issue gives me the impression that you regard the objections raised by the Philadelphia County Medical Society as the first protest against inclusion of physicians' services in group hospitalization contracts.

Group hospitalization was planned for Akron, Ohio in 1936, and started to operate in April, 1937, under the name of the Hospitalization Service Association of Akron. The promoters expected to include anesthesia, x-ray, and pathology. But our society definitely ruled out the services of physicians. It went even further and ruled out anesthesia, regardless of who gives the anesthetic. Thus, anesthesia is not included even in the two hospitals which have nurse-anesthetists.

No hospitalization insurance service can carry on without the cooperation of the local medical society. The services of physicians "free" or without extra costs are not necessary to the success of such a plan. The insured gets more than enough value for his

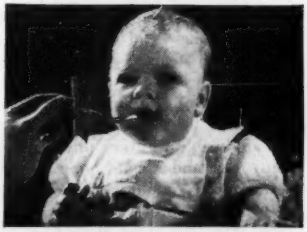
On the road from bottle to dinner table

"Peggy Lou" Armstrong at 3 months

Her first solid food—Clapp's Strained Baby Cereal—has advanced Peggy Lou appreciably on her way toward adult diet. For, though well-strained and smooth, this baby cereal is not too liquid. It is a mistake, pediatricians say, to keep a baby marking time on baby foods that make scarcely any new digestive demands. The texture of each Clapp Food is approved by baby specialists.

"Peggy Lou" Armstrong at 8 months

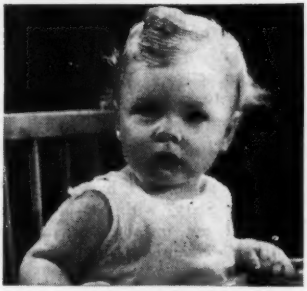
Every month, Peggy Lou has gained more than a pound and grown 1½ inches. At 5 months, she was gradually introduced to Clapp's Strained Vegetables, rich in vitamins and minerals. These growth factors are assured for Clapp's Foods by fresh-picked produce and quick pressure-cooking.



"Peggy Lou" Armstrong at 10 months

She can walk around chairs now, and apparently she has never stopped growing for a single day. Since she was 9 months old, all 16 of Clapp's strained vegetables, soups and fruits have been on her diet list. So she has developed a welcoming attitude toward new flavors, and a capable digestive system, uncoddled by foods that are too liquid.

Clapp's Foods are made to fit the highchair baby's needs exactly, by a company that makes nothing but baby foods—that offers the largest variety—and that pays unusual deference to the reports of laboratory and advising physician.



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money without a doctor's services being included.

Our society is represented by the presence of three members on the governing board of the Hospitalization Service Association. The society, the association, and the hospitals are all working harmoniously, with the result that the project has been a pronounced success. . .

A. S. McCormick, M.D., Secretary
Summit County Medical Society
Akron, Ohio

SIXTY

TO THE EDITORS: Dr. Edward Parker's article, "Prepare for Sixty," [October issue] is timely and very much to the point. It invites the serious attention of the profession.

The idea of beginning at age forty to prepare for specializing at sixty is not applicable to every physician, but many can and should plan to adopt this scheme. Possibly at 55 rather than at 60, one should commence to steal away from the grind of routine work. This plan is just as applicable to the physician in the hamlet as to the one in the city.

To be active is to keep young, to retire is to invite decay.

E. J. Angle, M.D.
Lincoln, Neb.

TO THE EDITORS: I have read "Prepare for Sixty" with considerable interest. I am in absolute agreement with the essential thought expressed by Dr. Parker.

As in past years, many physicians now expedite their early demise with the drudgery and irregular working hours of a large general practice. But if they limited their practice at sixty to a specialty which would provide regular hours of rest, they'd still be hale, hearty, and enjoying practice at seventy.

For years specialists have advised medical students and interns to practice general medicine for a few years and then secure a residency in a hospital for training in a specialty. But it is more logical and practical to finish training in a specialty before engaging in the general practice of medicine. This plan for the medical student and intern fits in admirably with Dr. Parker's suggestion.

The student graduating at 25 would take a year's internship in some general hospital. By the end of his internship, he would have decided upon a specialty. He would then immediately obtain residency training of from two to four years in that specialty. If it happened to be some branch of surgery, it would then be well for him to spend one year in a laboratory getting much needed training in the examination and pathological diagnosis of surgical specimens.

After one year in the laboratory, he would continue with special training for at least two years. He would then be ready to begin general practice around age thirty. During general practice he would, of course, continue his active interest in his specialty.

Soon after age forty he would begin to give more and more time to his specialty. Then, in accordance with the suggestion of Dr. Parker, by the time he reached age sixty, his practice would be limited to the specialty he elected during internship.

He would have been a better general practitioner because of his early special training. Unquestionably, upon retiring from general practice, he would be a much better specialist because of years spent as a general practitioner.

Walter R. Carey, M.D.
Sheridan, Wyo.

TO THE EDITORS: The ideas contained in Dr. Parker's article are excellent. They show a degree of initiative and foresightedness which must make many of us feel all the more guilty by contrast. I am following a similar, though less energetic, program

with much the same thought in mind.

An important consideration (undoubtedly thought of by Dr. Parker, but not mentioned) is that a doctor following such a plan becomes of greater value to the community in general and to his medical colleagues in particular.

Certainly, a specialist basing his ability on a large and varied experience over many years, in addition to concentrated study, is preferable to the specialist who becomes so by an early intensive course while still a medical neophyte.

In time, Dr. Parker will find himself not only on an equal footing with other specialists in his field but above them. He will be pleasantly surprised to find his advice sought rather more often than he anticipates.

I hope many physicians, inspired by Dr. Parker's example, will go and do likewise.

Arthur Fankhauser, M.D.
Brooklyn, N. Y.

IRRELEVANT

TO THE EDITORS: Forms furnished by insurance companies for doctors to fill out in disability cases include too many questions and ask too much that is irrelevant. They consume the busy doctor's time, and in many instances he receives little or no compensation.

An insurance blank sent to me not long ago contained 27 questions—six with subdivisions, making 33 questions in all. At the bottom were the usual half dozen queries relative to the doctor's qualifications.

Six or eight pertinent questions should be sufficient for any such form. Is it too much to hope that insurance companies will get together on a short, standard blank for disability cases?

M.D., Indiana

CONFESSIONAL

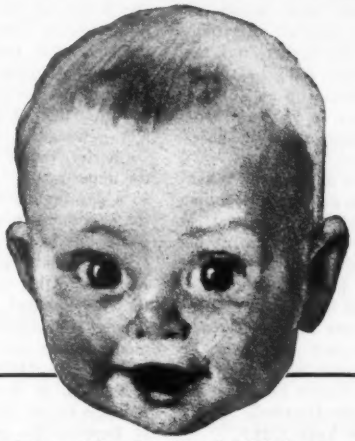
TO THE EDITORS: My attention has been called to the article, "Confessions of a Social Worker," in the October issue of your magazine. After reading it, I am lead to express the following conclusions:

It does not seem possible that a reputable medical journal would publish an article which would lead to such an untrue conclusion regarding a department of modern medical service which has been of so much value in helping the doctor to secure results with patients who come for clinical treatment.

This worker may well remain anonymous, for she has misrepresented the

Leader or Laggard

...WHICH IS THE STARTING CEREAL YOU RECOMMEND?



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social service departments of our hospitals. . .

I take issue particularly with her intimation that social service departments accept patients who can pay private fees. There is no good social service department that would not gladly reduce the number of patients coming to it. . .Nor is there any real social worker who would be so dishonorable as to build up an alibi for free care contrary to her own conscientious conviction as to the necessity for such care. . .

A social service department worthy of the name serves not only the patient but the hospital and medical staff as well. It makes every effort to prevent free care of patients for whom private treatment can be properly secured.

If this article is intended for satire, it certainly becomes slander instead.

Margaret Van Fleet,
Director Social Service,
Manhattan Eye, Ear and
Throat Hospital,
New York City

TO THE EDITORS: The social worker is only a link in the chain by which "free" medical treatment dangles. To blame her for the harm done to both doctor and patient is like blaming the pharmacist because a certain drug does not produce the desired result.

Every hospital administrator will admit privately (never in public) that "free" clinics are a substantial source of revenue to his institution. The greater the number of patients, the more half dollars and quarters in the cash register. Add to this the amount charged for laboratory and x-ray work (some items are charged at the same rate as in a doctor's private office), and you find a sum total of tens of thousands of dollars each year.

Not one cent of this sum goes to the doctor who works in the clinic!

It is the administration that shapes the policy of the institution and is interested in swelling the figures in its statistical report. These figures give the directors a good argument when appealing to the public for funds in the name of the poor who need free treatment.

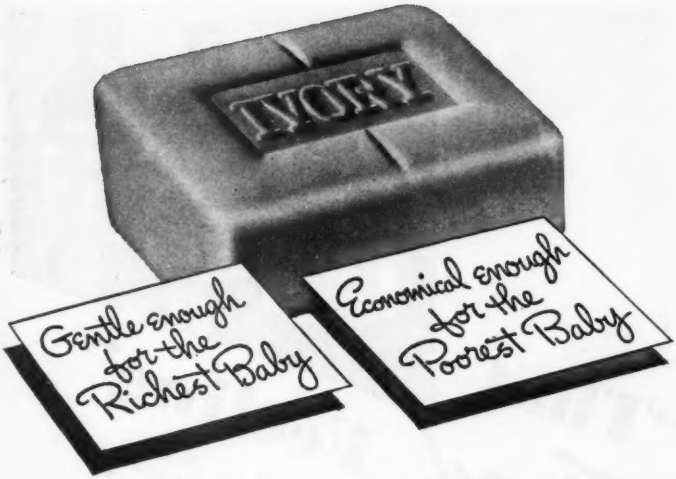
Charity, indeed! In my community the department of public welfare pays $3 a day for every free patient within the ambulance zone. *Yet nobody hears about this in the institutional reports.*

As long as physicians remain silent partners to this injustice, so long will they be exploited. True, the individual doctor is helpless. But collectively, medical men can put a stop to this endless exploitation.

As soon as the doctor is paid for his time in the clinic, he will indirectly improve his private practice. For the administration will no longer be interested in numbers, and admissions will be based on actual need. This will also give the physician a chance to practice medicine as he sees fit, rather than be concerned with the silent demand of the administration for a large attendance in his clinic.

When clinic admissions are based on actual need, and not with an eye on the cash register, the social worker also will be able to do her job properly: to teach people to rely on their own resources and not to lean continually on charity.

A Medical Social Worker
New York City



Doctors, Nurses, Hospitals everywhere advise Ivory for bathing babies

WHY IVORY SOAP IS USED IN SO MANY FINE HOSPITALS

Pick a hospital at random! . . . A cross-section of its case histories would doubtless show the soap of its choice to be *Ivory Soap*. Because most medical authorities have found that Ivory is so pure, so mild that it is a comfort to any skin—infant or adult.

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FREE TO DOCTORS: For your own personal use—6 cakes of mild, pure Ivory Soap—to acquaint you with Ivory's new waxed wrapper which seals OUT dust and germs, seals IN Ivory's famous purity. This "Purity-Sealed" protection keeps Ivory Soap as pure as the day it was made. Drop a postcard today to Procter & Gamble, Dept. ME-127, Box 629, Cincinnati, Ohio, and 6 cakes of Ivory will be sent you FREE! Mail in your request before March 1, 1938.

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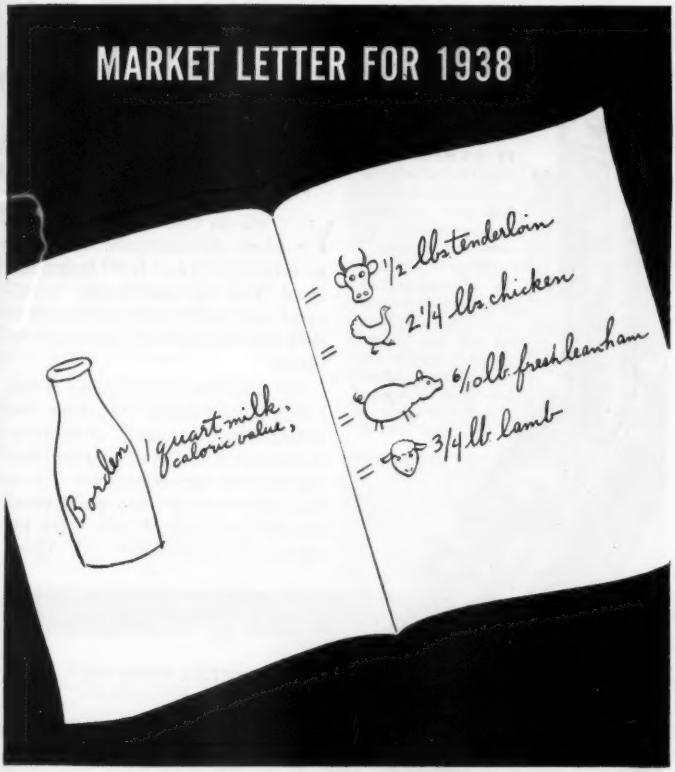

IF YOU have paid any market bills recently, we think that the above reminder of a few comparative food values may be of more than academic interest to you.

Naturally, the whole story of a food's value is not told in its caloric value alone. But... the case for milk as a true economy food is further supported by the facts that:

It is the most nearly* perfect *food.
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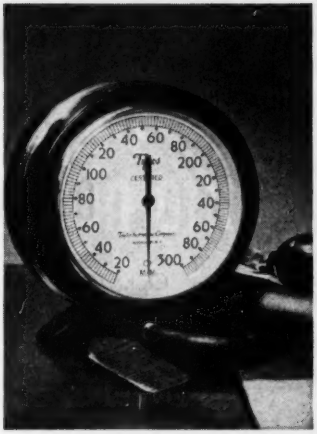
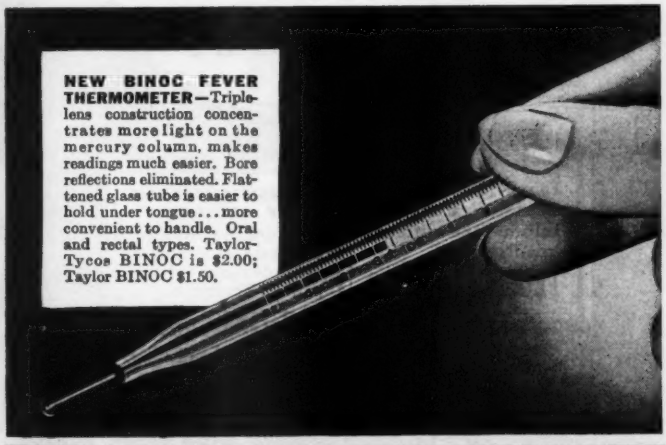


DESK-MODEL TYCOS ANEROID—One of the smartest looking instruments ever offered the medical profession. Occupies only four inches of desk space. Easily read at distance of six feet. Carries 10-Year Guarantee. Available also as Wall Model. $27.50 complete.



NEW BINOC FEVER THERMOMETER—Triple-lens construction concentrates more light on the mercury column, makes readings much easier. Bore reflections eliminated. Flattened glass tube is easier to hold under tongue... more convenient to handle. Oral and rectal types. Taylor-Tycos BINOC is $2.00; Taylor BINOC $1.50.

BINOC FEVER THERMOMETERS

☆ SIDELIGHTS ☆

ASKED TO NAME the most important type of insurance for the physician, the average practitioner would no doubt reply, "Ordinary life."

Yet a number of insurance men believe that insurance against disablement from ill health or accident is still more essential.

Who is right?

It makes little difference. The really important thing to remember is that every physician needs disability protection. If he doesn't have it, he should get it.

The belief still persists in many quarters that disability insurance can no longer be purchased. This is not so. Several sound, reliable companies continue to offer such coverage. As in the past, of course, it must be bought in conjunction with life insurance.

Stop for a moment and consider what you'd do if you were in an accident today which disabled you for life. Or if you fell victim to a disabling illness which laid you up for eight or ten years.

It's not a pretty thought. Hence this reminder to protect yourself—no matter how much it hurts to part with the premium.

Better act quickly, too. No one can say just how much longer disability insurance will be available. The number of companies issuing it has decreased steadily.

OF COURSE, YOU'VE READ the story of Robinson Crusoe. You recall that when he started to build a livelihood for himself on that desert island, one of the first things he did was to get himself a reliable Man Friday. After all, Robin had to have his mind free for the more important creative work.

It's the same way in building a medical practice. The successful doctor is the one who doesn't become too involved in detail, who leaves such

detail to a competent office assistant. As Joseph T. Mackey once said, referring to the executive who hires a chauffeur:

"He sits in the back seat and directs where the car shall go. He doesn't waste time and energy turning corners or watching traffic lights and stop signs. That job, important as it is, is not important enough for him. His job is to be thinking about what he is going to do when he arrives at his next destination."

A capable office assistant is a gem in any setting. Don't be satisfied with an inferior one.

Once you get her, begin training her at once. As time goes on, add to her responsibility. Assign her certain tasks for which she will always be held accountable. Encourage her to make decisions. If they go wrong, don't fly off the handle. Play the part of teacher. Instead of simply criticizing, help her to become more efficient and self-reliant.

The false economy of hiring cheap

personnel should be obvious. Employ a girl who's really good, and pay her what she's worth. You'll get your money back many times over in added service and increased practice.

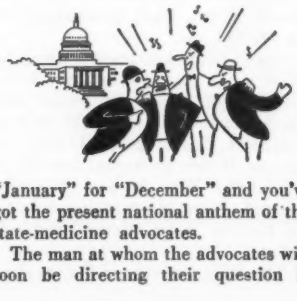
Just as the physician needs an efficient secretary, so the secretary needs efficient, up-to-date equipment. For even the best workman cannot get results with poor tools.

Believe it or not, some physicians we know still send out their bills in longhand. Others have typewriters—and what typewriters! The latter are as battered as a cauliflower ear. They don't register evenly. The results are appalling. Imagine the impression a letter from such a machine makes on patients!

Again, take the case of a practitioner who estimates the value of his time at, say, $10 an hour. Sometimes he'll waste $5 in a half hour's vain hunt for something he should have been able to find in a minute. Think how often this can happen, too. Consider how much time may be lost over a period of a few years. Then compare the cost with that of a simple but orderly filing system.

We have been in offices that lack even a pencil sharpener. Yet a standard one is only 89c. And it's not made in Japan, either.

"WILL YOU LOVE ME in December as you did in May?" ran the refrain of an old popular ditty. Substitute



"January" for "December" and you've got the present national anthem of the state-medicine advocates.

The man at whom the advocates will soon be directing their question is none other than Senator Robert F. Wagner, of New York.

It will be remembered that Senator Wagner plighted his troth with the health insurance lobby last May. The place was Indianapolis. His audience, the National Conference of Social Work.

The gentleman from New York lost no time in taking the social workers to his bosom. Greeting them as "comrades-in-arms" and as "the real standard-bearers of civilization," he affirmed that the "unity of purpose is now complete between the social worker and the public servant."

He proposed—in soft language, to be sure—an alliance between the social worker and the bureaucrat. Together, he suggested, they would take the matter of health out of the province of the private practitioner. To cinch the bargain, he promised quick extension of the Social Security Act for this purpose. "Vistas of human achievement stretch before us," he declared ecstatically.

Happily, those vistas, so bright and shining to the Senator, and so black and threatening to the physician, are still before us, not behind us. Of late, Senator Wagner and his colleague, Senator "Ham" Lewis, have been remarkably quiet on the subject.

But Congress reconvenes in January. The entire medical profession will be looking to that session with its fingers crossed.

MANY MORE of our country's economic principles than our sophisticated citizenry suspect were originated in some frontier barn. The occasion may have been a husking-bee, a housewarming, or a mid-winter chat around a glowing stove. It may have been any one of similar excuses used by our forefathers to get together for the consideration of common problems.

The mental aids consisted, perhaps, of nothing but a cracker barrel or a

fiddler scraping in the corner of the room. But the informality of the gathering had its advantages. Opinions were aired which, if expressed anywhere else, would have resulted in a hanging. Decisions were made that have had far-reaching consequences.

Much of this same spirit is caught by the Ohio State Medical Association in its *mid-year organization conference*. Only, the passing years have added a touch of luxury in keeping with modern life. Instead of bare rafters as a background, doctors who attend enjoy the comfort of a modern hotel.

At the last conference, held on October 24, subjects discussed ranged from a proposed credit-rating plan to the Farm Security Administration's "cooperative" medical program.

"Here's the way our men take an active part in the general election," says the M.D. from Urbana, and launches into his explanation.

Shortly afterwards, his neighbor from Toledo plunges into a description of the way he and his colleagues cooperate with the public press. The variety of subject matter is almost limitless.

The conference is *not* an official activity of the state association, as are the meetings of the house of delegates. Its enthusiastic proponents would resent any attempt to make it such. This is appreciated by the county committeemen who are the association's guests. They pitch into the free-for-all discussion with gusto. Around the table (at which a complimentary luncheon is served) they chat about improvements in medical practice worked out in their home territories. There is none of the business of passing resolutions and asking the county society to submit these resolutions to the state association or the American Medical Association for consideration behind closed doors. The poor country doctor is on the same level as the man with the wealthy city practice. As often as not, it is he whose suggestions make his city cousin sit up and take notice.

The Ohio conference is a grand institution. Its atmosphere of studied casualness alone makes it worthy of emulation by state societies elsewhere.

IT'S GETTING SO that everybody who doesn't swallow John L. Lewis' doctrines piecemeal is an enemy of labor. For all we know, we may find a couple

of pickets outside our door the day after this appears. Nevertheless, we feel we ought to point out the threat to public health implicit in a recent decision of the C.I.O. in Newark, N. J.

The trouble arose over a contract with a local novelty firm. It was not that this company refused to pay a living wage or that its hours were too long or that it refused to recognize the right of collective bargaining.

On the contrary, this firm merely wanted to protect the health of its employees. It asked that its workers be required to furnish a physician's assurance that they did not have syphilis. William J. Carney, regional C.I.O. director, rejected the request. He decided the union would strike rather than submit, as he said, to such a "silly" clause.

By meddling in matters of health, the C.I.O. is setting a bad precedent. If every local labor leader took the attitude of that Newark director, we would shortly be back to the medical world of the Middle Ages. We advise the C.I.O., therefore, to stick to its industrial knitting and to keep its nose out of the affairs of the medical profession.

YOU MEET SUCH

INTERESTING PATIENTS!

BY CHARLES KENNEDY, M.D.

WHY NOT BECOME a hotel doctor?

Yes, I know the answer sometimes made: "What! Become one of those parasites who spends his life convincing guests they have imaginary illnesses, whose most important case is an acute hangover, who fills the gap only until a 'real' physician can be obtained? Not for me!"

If that's all that holds you back, then your shingle is as good as up in a hotel lobby. For such a conception is as realistic as that of the detective who wears a fore-and-aft peaked cap, has flat feet, and searches for clues with a magnifying glass.

The house physician of the average urban hostelry is a graduate of a Class A medical school. He has a Class A internship. He belongs to his county medical society. His morals are irreproachable.

He has to have all those qualifications. If he doesn't, he won't be admitted to the Hotel Physicians Association of America. And if he isn't, the chances are he won't be retained by members of the American Hotel Association.

As a matter of fact, the average hotel physician is sometimes more competent than the ordinary doctor. He handles all kinds of cases under all kinds of conditions. He never knows what to expect.

Even his bag is different. He is confronted by so many heart attacks that it always contains a portable sterilizer. His morphine is ready in solution. Most of his emergency medication is carried in ampules. He knows just where he can lay his hands on oxygen in a few moments. He has arranged with the local hotel to supply heating pads, ice bags, electric fans, and air-conditioned rooms for his patients. He has the address of every nearby nurses' registry at his fingertips. He is prepared for anything short of a major disaster.

Furthermore, he has to be an ace diagnostician. A patient is normally seen once; occasionally several times. His idiosyncracies, physical peculiarities, and medical history are unknown. Nor do most patients entirely trust the hotel doctor. When they get home, they have their family physician check his findings. If there is a mistake, it will be discovered. Unpleasant repercussions will follow.

Moreover, a large proportion of his cases are serious. It has been estimated that in 90% of hotel calls, a physician should have been summoned from 36 to 48 hours earlier. This is because travelers put off sending for a doctor until it is absolutely unavoidable.

There are two types of physicians affiliated with hotels. The first

is the resident, usually connected with a large establishment. He lives on the premises, has no outside practice, but devotes all his talent to guests, employees, and the management. He must often meet the rigid requirements of the H.P.A.A. There are about 1,000 such physicians in the United States.

Obviously, the *majority* of the nation's 19,000 hostelries can't afford such a doctor. Instead, they rely on a nearby M.D. for medical protection. While maintaining his own practice, he agrees to accept hotel calls.

Many private practitioners have found the role of part-time hotel physician exceedingly to their liking. Not only is it a lucrative sideline but it frequently produces contacts that lead to further private visits. Nor does it involve the expense of becoming a member of any organization. It finds great favor with the middle-aged man who has just moved his practice. And the connections it entails are often used by younger colleagues as a foundation for their future practice.

I know several successful physicians a number of whose patients were met in the course of such work. One in particular comes to mind now. As a young man, he took whatever the hotel offered him. These included drunks, brawlers, and whatnot. As the years went by, a number of the better class of guests became regular visitors at his office. Today, a couple of younger men do the run-of-the-mill work while the management calls him in on the better cases.

Whether you seek a part or full-time job as hotel doctor, the approach is the same. Most hotel practitioners, I believe, stumble into their jobs through acquaintance with the owner or manager. But this is not a hard-and-fast rule. A common-sense method of securing this sort of employment is to mobilize the names of the hostelries within a reasonable distance of your office or home. Phone them. You may quite possibly find some that are not covered medically.

[*Turn the page*]

GREAT MACE OF THE COLLEGE OF SURGEONS

BRIGHT in the colorful induction ceremonies at the recent annual meeting of the American College of Surgeons was the Great Mace. It was carried in the processional. A gift from British army surgeons, the mace commemorates their fellowship with American surgeons during the World War.

Made of hand-wrought silver and British oak, the mace is symbolic from the "Sacred Flame of Science" on top to the leaves of *Isatis tinctoria* at the bottom. Other symbolism in its design is achieved through Canadian maple leaves, American eagles, and the floral emblems of the United Kingdom—rose, thistle, shamrock, and leek.

These are the ones to follow up with talks to the officers. You will find them interested. They are always anxious to have a doctor handy for emergencies. Some guest or employee is always falling ill. The management is only too glad to have a doctor on call.

If you do compensation work, insurance companies may furnish you with a list of hotels without a physician.

Hotel proprietors in general have a keen realization of the value of a good doctor to their business. This has made them, in some cases, extend him the courtesy of a free room. Sometimes, in return for such a favor, he is expected to examine and attend without charge all employees. On the other hand, where the connection will obviously afford a lucrative income, he may be expected to pay for all accommodations. Sometimes his exact relations with the management are stipulated by contract. Just what he gets or gives varies so much that there isn't any rule. There are almost as many agreements as hotel physicians.

The hotel doctor also gets part of his compensation in experience. Several years of such work give him a resourcefulness exceeded not even by that of the M.D. alone in a country practice.

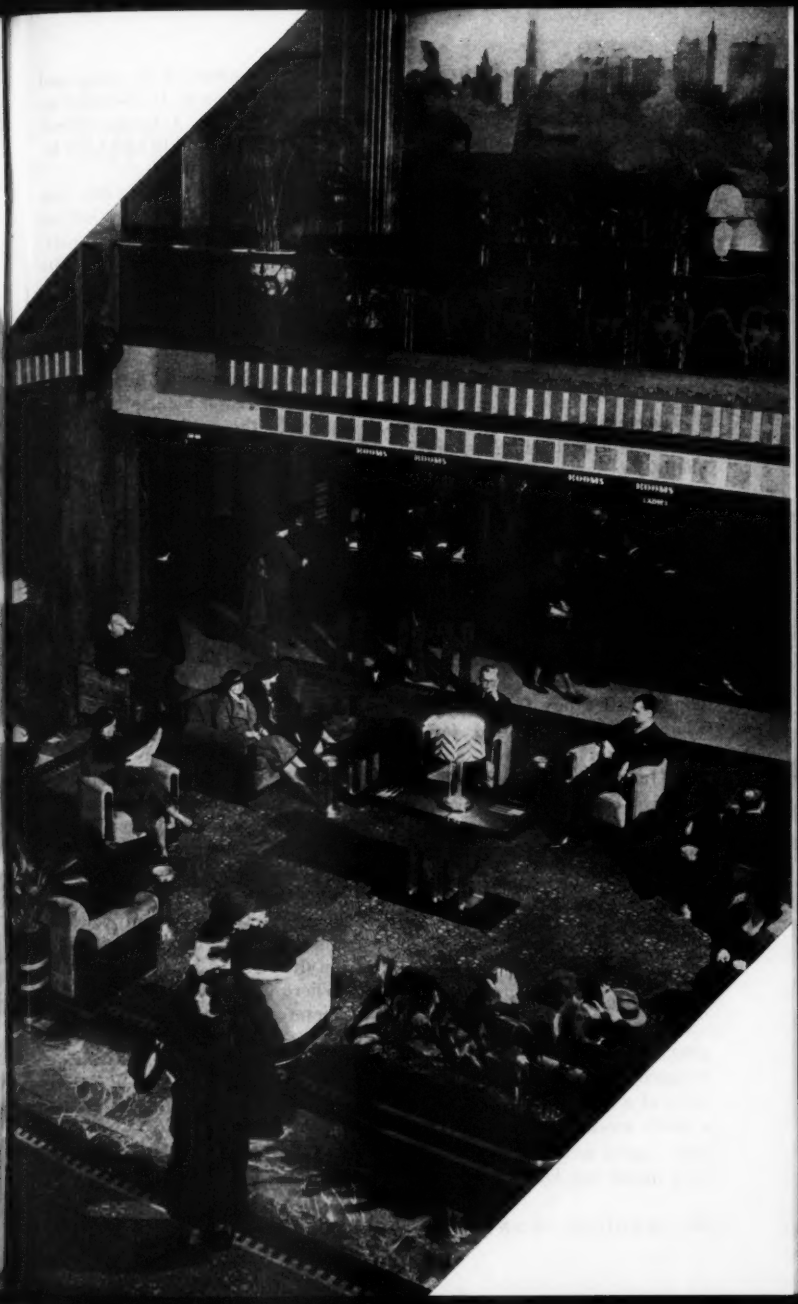
Many men prominent in the life of our country have recognized what they owe the hotel physician; sometimes with good-sized checks. When this happens, the hotel doctor usually deserves it. In his way, he is probably as good a humanitarian as any of his colleagues. As an example of this, I am reminded of what happened one night at a Chicago caravansary:

A gentleman and his wife, from out of town, spent the evening at the theatre. Returning to their room, the wife was stricken with a hemorrhage. The young assistant house physician, called at one o'clock in the morning, decided it was an ectopic pregnancy. He told the husband that unless his wife was removed immediately to a hospital, she would bleed to death. Husband and wife both scorned the idea.

The assistant got his chief out of bed and informed him of his suspicions. He hurried over and confirmed the diagnosis. Still the couple were inclined to delay the matter until morning. In vivid language, the hotel doctor pointed out the almost certain result. Finally, with reluctance, the wife agreed to be taken to the hospital. Her operation was successful. That woman can thank the hotel physician for her existence today.

It may surprise the average practitioner to know that a number of travelers depend exclusively on

Every hotel is a city in miniature. And one of its most important citizens is its physician. More than any other, he learns the secret weaknesses, troubles, and aches of its constantly shifting population. If you've ever wondered what such a practice is like, you'll enjoy this description of the life of a hotel doctor by a man who is one.



hotel doctors for their treatment. Mr. Humbert, on the road for a steel company, never fails to get his intra-muscular injections, even if his stay in the city is only a few hours. He sees a hotel physician in Detroit who gives him injection No. 1. This man recommends an associate in Cincinnati, his next stop. The patient is given a card describing the diagnosis and treatment schedule. As he continues on his journey, the chain of care is continued by hotel doctors in other cities.

The responsibilities of the physician in a first-class hostelry are many. Not the least of his duties is to serve as a miniature board of health. He must handle the guest who develops a contagious disease as well as take measures to prevent its spread to other roomers. He must know how to treat alcoholics, drug addicts, and attempted suicides. He has to inspect the plumbing and kitchens. He averages perhaps a call a day from employees who want compensation for cut fingers, skin irritations, and the like. In such situations, he is the buffer between the employee, the compensation board, and the insurance company.

In addition to having the foregoing qualities, a hotel physician must be gifted with the bloodhound instincts of a district attorney. Hotels are often the victims of frauds involving alleged accidents.

The most common trick is slipping on a floor. One day a man dragged himself into the manager's office of a Milwaukee hotel. He had a badly swollen ankle. He said he had tripped on a rug. On the doctor's recommendation, an inspection of the scene of the supposed accident was made. It disclosed no rug there at all! A further check showed that the ankle had been injured outside the hotel.

Of course, after reading this, you may decide that you are not cut out for a hotel practice, even a part-time one. It is true that it has its disadvantages. You are on call at all hours. There is likely to be a preponderance of cases that prove distasteful.

But mixed with the bitter is the sweet. While the hotel practitioner is hardly the robber he is often made out to be, his fees are comparatively high. A frequent charge is $5 for a day call and $10 for a visit after 10 p. m.

There are reasons for that, too. Many of his cases are emergencies, requiring removal to a hospital and demanding considerable of his time. Obviously, patrons of an expensive hotel are able to pay a fairly substantial bill. As a hotel is really a small city, gathered under one roof, he doesn't have the inconvenience of travel. And normally, he is paid cash immediately after treatment. Or the patient may prefer that the bill be placed against his hotel account. In that event, the hotel assumes the obligation and collects the doctor's bill itself. Thus, the only "deadbeats" encountered are emergencies from the street.

Where else could you have such an interesting career? Life in all its color flows before you in a constant stream of world travelers; men of affairs; Hollywood stars; characters of high life and of the underworld; politicians, potentates and prostitutes. It's a grand life—even if you live it.

TRY THIS ON YOUR PIANO!

By Frank Howard Richardson, M.D.

CAN A DOCTOR who loves music, but has never taken music lessons, learn to play the piano in middle life?

I'd have said no a few years ago; for the reason that no doctor I've ever known would put in the dreary hours of practicing which music teachers say are indispensable.

I had tried and failed three separate times for that very reason.

Well, I was wrong.

I've since learned a lot about playing the piano. And I've never practiced one single minute!

As a result, I still love to play. My love for playing has never been killed by the hours of gruelling practice that have made so many folks hate it.

But isn't it *impossible* to learn to play without practicing? That depends on what you understand by the verb, "to practice."

To me, practicing implies a deadly routine, pursued doggedly in the hope of some day being able to make music. It may be fatiguing scales; it may be foolish little exercises; it may be childish "pieces"

The "hunt-and-peck" system won't make you a concert pianist, but it does make for a lot of fun, this author claims.

that no grown man would want to be caught playing. Few doctors of my acquaintance could or would spend so many hours in uninspired drill.

But my own experience has proved to me that you can begin to play *right away*, without any such painful apprenticeship. You need never stay at the piano longer than you wish. And you can begin to make some sort of music the first moment you sit down.

That's exactly what I did. I never play when I think I ought to, but when I want to—that is, whenever I can steal time from my daily work as a pediatrician.

What makes my playing absolutely unlike practicing is the fact that I stop the minute I want to. Whether I have played an hour or five minutes, I quit as soon as I feel like it—with never a qualm of conscience, either.

If I want to take three lessons a week, I do so. If I want to go for six months without taking a lesson, why that's my business.

My study of the piano, begun in middle life, has proved to be the most delightful hobby I've ever known. It is destined to continue, from all present indications, until I change my piano for a harp.

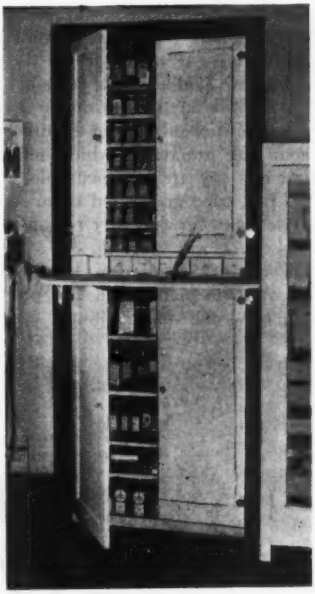
If you want to know how it all started, here's my confession.

While listening one day to a piano lesson one of my children was taking, it occurred to me to ask the teacher if she had ever taught music to an adult; if she believed a grown man could learn to play; and if she'd be willing to try to teach me? She never had; she was quite positive that she could; and she would be delighted to take a shy at the job.

It was just as simple as that!

While waiting the few days necessary for a book for adult beginners to arrive, I dug into the heap

DRUGS IN THE DOORWAY



HAVE YOU ONE DOORWAY too many in your office? If you have, don't board it up. Instead, fit thin wallboard to the far side. Add shelves and cabinet doors. This makes a handy cupboard. By equipping the shelves with uniform, short bottles, a large volume of drugs may be kept in perfect order. Or the space may be used to store other small articles.—FRED M. F. MEIXNER, M.D., Peoria, Ill.

of old, ragged piano music we had in the house. I placed a sheet of what looked like comparatively easy stuff on the rack, and began with extreme difficulty to pick out the notes. One by one, I played them on the piano.

Sometimes it took me several minutes to work out a single chord. Doesn't sound very exciting, does it? Yet it held me spellbound. I derived a totally unreasonable and inexplicable degree of pleasure from bringing out, even in this halting fashion, some of the lovely old harmonies I had known and loved.

All my life I had heard other folks make the music I was fond of. Now, at long last, I was beginning to make it myself!

That first afternoon my own peculiar method of learning to play the piano took form. It's the only one my teacher has ever used with me; though, of course, we have added a great deal to it.

I've played that way for three or four hours at a stretch. One night, when everyone was away and the house was mine without interference, I played for five solid hours. Only a glance at the clock finally brought me to my senses, and sent me clattering off to bed.

I played so long because I wanted to—not because I thought I ought to. In fact, I knew I ought *not* to. . . Which may have been why I did it!

"But see here!" some skeptic is bound to interrupt. "If you knew notes, you weren't a beginner. Your method wouldn't work with *me!*"

But it would. Here is the only musical stock-in-trade with which I started: I knew "C" on the staff. I knew middle "C" on the piano. And if you'd let me go slowly enough, I could say my "a,b,c's" forward or backward, up or down, on the notes or on the keyboard.

To be quite honest, I knew one thing more: That the initials of "E-very G-ood B-oy D-eserves F-un" identify the lines of the treble clef; while the initials of "G-ood B-oys D-eserve F-un A-lways" denote the lines of the bass clef.

At the end of a week of this groping, I crammed a few pieces of music into my brief case, hopped into my car as though off for a round of calls—and landed at my music teacher's for my first lesson.

Here was where my musical future trembled in the balance. Had she laughed at my fumbling fingers or blasphemed my many faults, my musical career must have died a-borning. Instead, she simply suggested some little thing here and there, praising me, for the most part, inordinately.

Not that she praised my playing. That would have been ridiculous. She praised me for my effort—for trying at all—just as Dr. Johnson praised the dancing bear.

Didn't I ever employ any drill, or practice? To be sure, I did. But only when I felt special need of it and asked for it to help me play some particular piece. My whole thesis is that interest will supply all the necessary drill—which is then no longer drill, or "practicing," but an interesting means to a desired end.

What are the pitfalls—the "don't's"—in my self-discovered method?

First, never defer until the future the pleasure to be derived from playing today. Get your pleasure now; or you never will get it.

[*Turn the page*]

Second, never play any piece you don't enjoy.

What? No exercises, scales, or difficult passages? Yes. But only if you want to do them—not because your teacher tells you they'll do you good.

Third, don't expect to delight the family or dazzle your friends. If "they laugh when you sit down at the piano," it will be with a raucous, horse-laugh. And if you try to show off, you're doomed to bitter disillusionment. The family will no more rave over your prowess than you will grow lyrical over their golf scores or their bridge prizes.

Fourth, don't let the faster progress of others discourage you. Like the little elfman in the song, you are quite as big (or as fast) for you as others are for themselves.

Last of all, don't play to entertain company. The ghastly business of boring a roomful of guests with parlor performances went out with bustles and straight razors.

The first thing I ever studied was McDowell's "To a Wild Rose." I'm still working at it, and I hope never to exhaust its wistful loveliness. I like to browze through old hymnbooks, to discover in this somber setting the sheer beauty of some of the things Arthur Sullivan and Barnby wrote. Books of popular songs, national anthems, and folk tunes are often a source of surprisingly simple and amazingly beautiful pieces.

How well do I play these things?

Well, some better and some worse. All I can say with complete truthfulness is that my playing fascinates *me*. And since no one else is ever going to be asked to listen to it, that makes it unanimous.

After all, I don't suppose even Paderewski feels he is perfect. My playing is so *much* better than I ever dared hope for, that I sometimes wonder how it's possible.

If your hobby is playing the piano, go to it as I did. You're bound to succeed, unless you allow yourself to be contaminated with outworn ideas about "music lessons" and "practicing." Much of the system I discovered for myself is being made the basis of modern musical education. And the graduates of such educational systems love music—which is the greatest proof of their success.

Carlyle once said: "Happy is the man who has found his work; he can ask no greater blessing." Paraphrase that to read: "Happy is the man who has found his hobby; he'll enjoy it so much that he'll never think of asking for a greater blessing."

If you want to learn to play the piano, go to it now. You'll never be any younger. Don't miss another day of music that might have been yours, for lack of the mere courage to begin. You've nothing to lose, and a whole new world of pleasure to win!

CLEANING INSTRUMENTS

DON'T THROW AWAY instruments such as scissors and forceps that have become so corroded they will no longer work smoothly. The débris that commonly gums up their joints may easily be loosened by application of a small amount of paint- or varnish-remover. It can then be wiped away with a cloth.—M.D., Nebraska.

INTERNS CAN TAKE MONEY

PART TWO *The opening instalment in the story of the American intern discussed the forces behind his drive for $1,000-a-year salaries in New York City. This, the second article in the series, is based on 100 replies to a questionnaire sent by* MEDICAL ECONOMICS *to 300 interns throughout the United States. It seeks to answer two present-day riddles of the hospital-intern relationship: "What does the intern want?" and "What does he get?" Hospital administrators and more interns will be heard from in succeeding issues.*

HE BELIEVES he is no longer a student but a professional man. He estimates his services as worth $811.78 a year, besides laundry and keep. He does not consider the educational value of what he does equal to the strain of his long hours of work. He cites his lack of pay as the chief among many abuses foisted upon him by his superiors. He denies emphatically that interns should pay for the privilege of interning, as is sometimes suggested. He is thoroughly dissatisfied with conditions at his particular hospital.

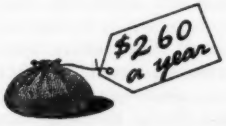
He is the American intern. The above is his portrait, sketched boldly and clearly by himself in 100 answers to a questionnaire sent to 300 interns by this magazine. The result is no mere guesswork, but a composite picture obtained from a careful tabulation of the replies.

The 100 institutions represented by interns who replied to the poll are located in 32 states. They are of every conceivable type. They include traditional and hallowed institutions in the East and South as well as their newer brethren of the

WHY INTERNS SEE RED

Average intern WANTS

Average intern GETS



HOME, SWEET HOME

International

Here's the garret one intern calls "home." Note the battered dresser and sagging cot. That broken chair is for guests—everybody else knows enough not to sit on it. At least this room's occupant can't complain of the cold. Steam pipes underneath keep the floor red-hot. A good place for Hindu firewalkers, if not for interns.

Middle and Far West. They range from a tiny dispensary perched on the Florida Keys to a vast Brooklyn "mill" whose 120 interns have to tread like demons to keep up with a grist of 3,500 patients.

The tabulation reveals one point clearly and promptly: That among those engaged in their medical fifth year, state boundaries no longer exist; sectional differences are forgotten; size and sponsorship of hospital are inconsequential. Interns of today, in institutions big and small, the country over, are facing the same problems. Of these, the most acute—and the one which is most likely to incite them to rebellion—is the financial question.

Above all, the doctor-in-training insists that his services be evaluated in dollars and cents. He and his colleagues are almost unanimous in their demand that the ancient adage be reversed to read, "And his hire shall be worthy of the laborer."

Of 100 replies to the question, "Should interns be paid?", *only two were negative.* Asked to cite the major deficiency in the present intern system, they pointed unhesitatingly to "compensation." Such considerations as poor lodging and food (stock complaints of the intern of old) were almost lost in the shuffle for remuneration.

A glimpse at the salaries paid

most interns is enough to account for this. The government of New York City, in planning compensation for interns in its municipal hospitals, set $1,000 a year as a "fair" standard. Yet *not one intern queried by* MEDICAL ECONOMICS *receives that much!*

The best the hospitals can do, apparently, is the $900 offered by an upstate New York institution. Throughout the rest of the United States, the highest figure reported was $600. Only eight institutions represented pay $500 or more and the nation-wide average is $260.23.

The conservative New England and Middle Atlantic states set a national low of $216.20. Moving westward, the average rises from $227.25 in the South and $260.35 in the Midwest to hit an apex of $325.66 in the West.

Over 16% of the interns who replied work for exactly nothing a year.

But why should the intern need money? He gets his board, room, and laundry, doesn't he?

Ninety-seven of the 100 interns do. In the remaining three cases, an allowance is furnished by the hospital for necessities.

But among the interns generally, dissatisfaction with their "handout" is rampant. Here are a few typical criticisms, picked at random from many in similar vein:

"I have interned in three hospitals. Never have I received decent food or sufficient privacy."

"Bugs are all over the room."

"We have as many as ten sleeping in one room."

"The food is cooked in mass, cafeteria style. It is almost inedible."

"My lodgings are literally lousy."

Nor is the intern of today content with mere "good living," even when he has that alone. The depression has taught him, like his fathers, to think increasingly in economic terms. As one realistic youngster expressed it:

"Our civilization is based on economic standards. An intern who is a pauper is apt to find it difficult to keep his station. Money is required to maintain position."

Such a youth—and there are many of them among the 100 heard from—looks upon the $10,000 or more his medical training has cost as an investment. More than likely, it is his only resource. His parents are already drained. He himself is saddled with debts incurred in medical school. He hasn't the time to take a part-time job as he did in college. His code of ethics forbids him to accept tips from patients. He is 25 or 26 years old and anxious to stand on his own feet. Somehow, somewhere, he must grab a year or two's practical training and enough funds to start a practice.

In his desperation, it is only natural for the intern to turn to the hospital for relief. After all, he reasons, his years of higher education must be worth something. He works almost 24 hours out of a possible 24-hour day. He sees the thread of life often dangling in his hands. He performs endless drudgeries that belong rightly in the precincts of orderlies, technicians, nurses, and stenographers. He is "unmercifully bossed" by staff doctors and even nursing supervisors. And he notices that while the hospital "begrudges" him a decent wage on the ground of professional

ethics, it does not use that argument to decline any of its own fees.

Nor can he discover among the other employees, from the elevator boy to the superintendent, any similar discrimination. Consequently, the conviction grows firm within him that he is being cheated. This feeling is aggravated when he spies apprentices in other fields—his classmates who have gone into law, engineering, or journalism—being paid for what the hospital tells him is the "privilege of learning."

The testimony of the survey on all the above points is eloquent. A few excerpts will suffice to confirm the attitude of the average intern:

"I worked my way entirely through school. I have hardly ever had 15c for a pack of cigarettes at any one time...."

"Our work has a cash value to the hospital and the private M.D. Why should we not be paid? The only reason is that hospital administrators have found they can get interns for little or nothing...."

"Interns are being exploited by physicians in charge of private cases...."

"In emergencies and a great many routine problems, the intern is responsible. The blame is quickly placed on him by buck-passers. The staff physician thinks enough of our services to place us in charge of his patients. The remuneration should be ample...."

But ample it is not. The result is that his ordinary needs crowd in on the intern like goblins out of some horrible nightmare. He has been told that a doctor's standard of living should be an example for the community. But where is he to obtain money for even the essentials? For clothes, toilet articles, carfare, books, journals, illness, insurance, instruments, and recreation?

Where the hospital does not take over this responsibility, the intern does without many of these things—to his own detriment. One intern complained that he couldn't afford to buy toothpaste. Another that he had to give transfusions so that he could take his fiancée to a "respectable night club." A third that he was "shabby, unread, and in general disgrace for not being able to meet my obligations." A fourth sighed for the "finer things of life, like music."

Trivialities, some of them. But youth cannot bury its natural instincts in a round of ceaseless labor. The questionnaire presents a multitude of evidence to the effect that the average intern is "starved socially" if not physically. Recreation facilities of hospitals are often limited to tennis courts that resemble, as did one specific example, a "plowed field." Sometimes, they don't exist at all. Some hospitals don't even maintain libraries.

What is the solution?

For 14% of the interns interviewed, it lies in "good living." Provided with the proper facilities, this group asserted it would be content with little or no money. "Good living" was variously interpreted. One man put in a bid for a private dining room, a room to himself with a private telephone, a tennis court, pool room, and a reception hall where he could entertain friends. Another wanted home-like quarters ("not just a place to sleep") and tasty wholesome food. Given those and money for cigarettes and "relaxation," he said he would be satisfied. A third,

who asked for "the best in food," confessed that he combatted sleeplessness with frequent meals. His room would not have to be "stylish," he said, but "comfortable and warm." A fourth requested a clothes closet, $3 a week for laundry, and $1 a week for cleaning and pressing bills.

But creature comforts alone do not satisfy the great majority of interns. They want cash besides. No less than 22% agreed with their New York City confreres that $1,000 a year, plus board, lodging and laundry, is about right. One tacked on $50 more for good measure. Six others raised the ante to $1,200. One of this latter circle commented that those whose requirements were beneath this were "introverts," deficient in "confidence or ability," who couldn't put their knowledge into medical practice.

Another brave soul jacked his asking price to $1,800. But the breath-taker was the intern, now getting $240 a year, who made the proposal that he be raised to $3,000, plus room, board, and laundry.

Twenty-nine fixed their desired recompense at from $600 to $900. Thirteen thought they could manage on from $240 to $550 yearly. It is notable that *only two sought sums under the present average pay*, as revealed by the survey.

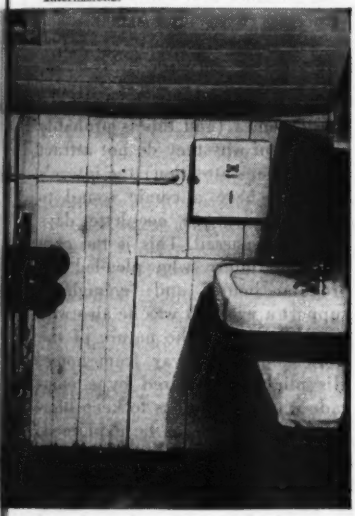
From the bare figures, it is difficult to determine just what an intern's standard of living should be. The responses to this poser were almost as various as the individuals concerned. One, who stated that he was for "minimum salaries only," suggested a sliding scale of from $25 to $50 a month. He split up his expenses thus:

1. Life insurance premiums and interest on small debts.
2. Cigarettes and minor amusements.
3. Replacement of clothing.

A contemporary, terming the $30

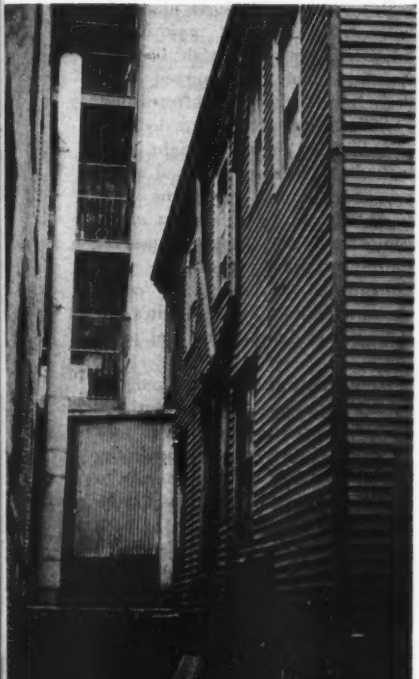
COLLECTOR'S PIECE

International



Tired after ministering to suffering humanity? Why not relax in this lovely example of the decorator's art? There's no shower, but an old-fashioned tub peeps out at the left. Those pipes probably won't fall in your lap. The piece of iron nailed to the wall will hold them in place. They will keep you warm, too—if you don't mind the drafts that pour through the cracks in the planked walls. Antique collectors may adore this washroom. Not so the six interns who use it.

"BLEAK HOUSE"



International

Charles Dickens called his novel, "Bleak House." That's a good title for this picture. But this isn't fiction. It's the intern quarters at a well-known hospital. In the background fire escapes may be observed. But those are for patients. What do the interns do in case of fire? Jump into the cement-lined alley. But isn't it hard? Yes, but an intern's life is hard, too.

a month he now earns "good enough for any intern," declared that "if a man is interested in money, he would have done better to have studied something else." Several were disposed to base payment on that of nurses, chefs, electricians, or skilled tradesmen. A mathematically-inclined intern calculated his annual needs this way:

Maintenance and clothes	$1200
Interest (6%) on $10,000 (cost of education)	600
Total	$1800

Sometimes (and this is probably one reason why they do not attract more serious attention) the intern's tragedies have a comic sound to the doctor whose neophyte days have long passed. This is the case with the intern who pleaded for "regular hours" and "enough to support a wife." It was he also who complained that the nature of the work kept him away from home. His plight was shared by a comrade who is ambitious to keep himself and his wife, as he explained, "in professional dignity."

So, in almost interminable variety and in tones that are clamorous and often angry, the cries of the interns rise like the chant of an Indian war song out of the night of their present conditions. For a room that is "well-lighted." a dormitory that is not too far from the hospital, enough money to "skim by with on the proper stratum of society," the same return as "members of the educated professions," a one-month vacation, free care for dependents, sufficient coin of the realm to "dress well" or to "open an office" or to "live out," just "$1,000 and a small

apartment for my wife," frequent physical examinations "in view of my hard life," free "shows put on by the hospital," week-ends and evenings off, private telephones, the same salary "as Henry Ford pays."

The hospital administrator may well emulate the Indian, put his ear to the ground, and listen.

—ARTHUR J. GEIGER

ANTI-SYPHILIS NEWS

DAY-BY-DAY BULLETINS from the front in the campaign against venereal disease grow in volume and variety. Following are highlights of the most recent:

Field Marshal—General John J. Pershing has agreed to lead the National Anti-Syphilis Committee of the American Social Hygiene Association. Said Dr. Ray Lyman Wilbur, the association's president, in announcing General Pershing's acceptance of the post: "Consideration was given to his successful leadership twenty years ago in bringing cantonment and community into close cooperation to reduce social diseases to such low figures among his military forces that world admiration was evoked."

Funds—A booklet being distributed by the American Social Hygiene Association in an effort to obtain $500,000 to finance social hygiene education describes what could be done with donations of various amounts. A $25,000 gift would pay five field workers' salaries for a year, or it would finance an anti-V.D. movie. A trailer properly manned and equipped to promote prevention could be purchased with a $10,000 donation. Also, $10,000 would finance a social hygiene exhibit at the New York World's Fair of 1939. One thousand dollars would subsidize the writing and production of three one-act plays on social hygiene for radio use. The cost of answering 1,000 letters of inquiry would be covered by a $100 gift.

Gotham—New York City's medical societies have compiled lists of private physicians willing to treat syphilitic patients at $2 or $3 a visit. These lists are being distributed to laymen through clinics maintained by the city's health department.

Legion—The American Legion in Indiana has decided that the state must have a law making premarriage Wassermans mandatory. It has resolved to lobby for such a law at the next session of the Indiana General Assembly.

Study—The Alabama State Department of Health is financing refresher courses at the U.S. Public Health Service venereal disease clinic in Hot Springs, Ark. Social security funds are being used. One physician from each county society is selected to undertake a one-month period of study. Transportation and a stipend ($200 for benedicts, $150 for bachelors) are furnished.

Advertising—The American Association of Advertising Agencies has interested itself in a campaign to reach low-income employee groups with anti-V.D. lore. As yet, an association committee appointed to study the project has volunteered no definite plan. However, there

are rumors of a federal advertising campaign. In the opinion of one advertising executive, $100,000 a year expended for three years would coordinate business' anti-V.D. activities. Executives would be taught how to educate employees, set up medical services in sufficiently large organizations, form clinics, and cooperate with private physicians.

SAN FRANCISCO FIGHTS CONTRACT SERVICE

San Francisco is in the throes of another earthquake. This time it's the coast city's medical profession that is erupting. The fireworks were touched off by a recent charter amendment establishing health insurance for municipal employees and their dependents. "This would deprive us," local physicians say, "of 60,000 prospective patients who would be turned over to contract doctors and contract hospitals."

Aligned against the profession is the Municipal Employees Health Service Board, administrators of the plan. This organization has asked San Francisco's Retirement Board to approve either:

(1) A complete contract service with Sutter Hospital to cover "medical and surgical attention," laboratory tests, x-ray examinations, treatments, doctors' visits, medicines, drugs, hospitalization, and annual physical examinations, for $1.75 a month. Or:

(2) A "free choice" plan which would permit the patient to select his doctor but would require individual payments of $3.50 a month.

The latter scheme, especially, has drawn the fire of private practitioners. They charge that it's a "blind" to make the free choice method appear too expensive.

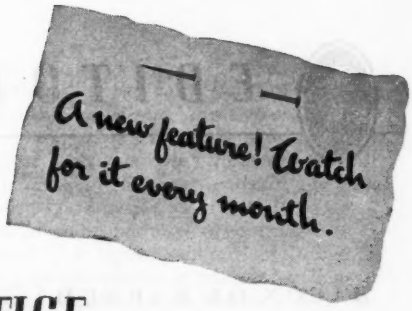
The San Francisco profession has countered with a third proposal. This would allow individual choice of doctor, hospital, and druggist. Services of all three would be provided at a cost of $2.50 a month, plus the first 15% of any bill. Fees would be further restricted by a fee schedule.

But the latter proposal does not satisfy the Employees Board. It describes the doctors' suggestion as "not sufficiently definite." It contends that there is no legal way to put it into contract form.

Professional support of the physicians' stand is growing. The San Francisco County Nurses Association has stressed a fat loophole in the Health Service Board's solution. It maintains that adequate care can not be supplied for $1.75 monthly, as called for in the contract.

The Northern California Retail Druggists Association has also come out strongly for the physicians. The druggists state they were duped when the charter amendment was placed on the ballot. They were assured, then, they reveal, that no physician or pharmacist would be barred from participation in the plan, but that restrictions are now imposed.

The matter is currently in the hands of the retirement board. It has sixty days (at this writing) to make a decision. If favorable action is not forthcoming, the doctors are prepared to take their fight to the courts and, if they must, into the legislature.



PLACES TO PRACTICE

LOOKING for a location? Then you may well investigate some of the towns listed on this page. MEDICAL ECONOMICS can *not* guarantee that each is a promising place to practice. But it *can* vouch for this much: One or more physicians have died during the past five months in each of the places named. Presumably, then, each may now have room for another doctor. None of the deceased was over 59 years old. The towns have populations of 50,000 or less, according to the 1930 Census. Data about the type of competition in a community, the financial status of the people, and general living conditions can best be obtained by a personal visit. MEDICAL ECONOMICS will gladly answer mail inquiries, however, about the population of any town, the number of physicians in it, and the hospital facilities available.

ALABAMA: Decatur, Minter, Prichard, Tuscaloosa

CALIFORNIA: Holtville, Pasadena

COLORADO: Brighton

FLORIDA: Trenton

ILLINOIS: Aurora, Rock Island

INDIANA: Muncie

IOWA: Greene

KANSAS: Emporia, Pittsburg

MAINE: Auburn

MICHIGAN: Crystal Falls

NEW JERSEY: Somers Point

NEW YORK: Woodhaven

NORTH CAROLINA: Midland, Pilot Mountain, Pinebluff

OREGON: Bend

PENNSYLVANIA: Sunbury, Upper Darby

RHODE ISLAND: Cranston

TEXAS: Orange

EDITORIAL

BACON OR BARNUM?

PHYSICIANS *everywhere, we believe, will agree that the intern has a right to a better existence. In the second article of the series,* "*Interns* Can *Take Money*" *(see page 31), the fifth-year student draws up a severe indictment of the conditions under which he lives and works. Vermin-infested rooms, unpalatable food, and salaries so small as to deprive him, in many cases, of the necessities of life are evils to be combatted. This, no matter on what side of the fence you may sit.*

The youthful physician may have a tendency to run to extremes. Due allowance may have to be made for his readiness to criticize his elders. But, in this case at least, he should be heard. His testimony is ample proof of the need for a re-examination of the intern-hospital relationship.

The seriousness of the situation is the factor that makes it pregnant with danger. By its very unpleasantness, the picture is calculated to please the socialized-medicine supporters and others with a zest for disrupting private professional enterprise.

Any dissatisfied intern MAY BE *a* POTENTIAL *trade-unionist, Communist, or both.*

No one realizes this better than the professional disturber. Nor is there anyone who knows better how to foment and capitalize on group discontent. There is only one way to eliminate his threat entirely. That is by beating him at his own game.

Alleviation of financial pressure on the intern would forestall any such movement as has been launched by the Interne Council of America in the municipal institutions of New York City. This is a matter that is squarely in the

hands of the hospitals. By paying a living wage, they will, in the long run, be helping themselves. If such action is not forthcoming, they will be the chief sufferers, along with the private practitioner and the intern himself.

To the intern, who is, in the final analysis, the individual most concerned, we would say this:

If you feel that local or national organization is essential to attainment of a higher standard of living, go to it. But see that your association is one that will never reflect discredit upon yourself or upon your fellow doctors. Insist that it be a truly professional organization and not a trade union in disguise.

Before you take steps that may prove fatal to your cause, be certain that your organization is devoted exclusively to the professional interests of the intern. Make sure it is not merely a front for radicals anxious to add interns to their ranks.

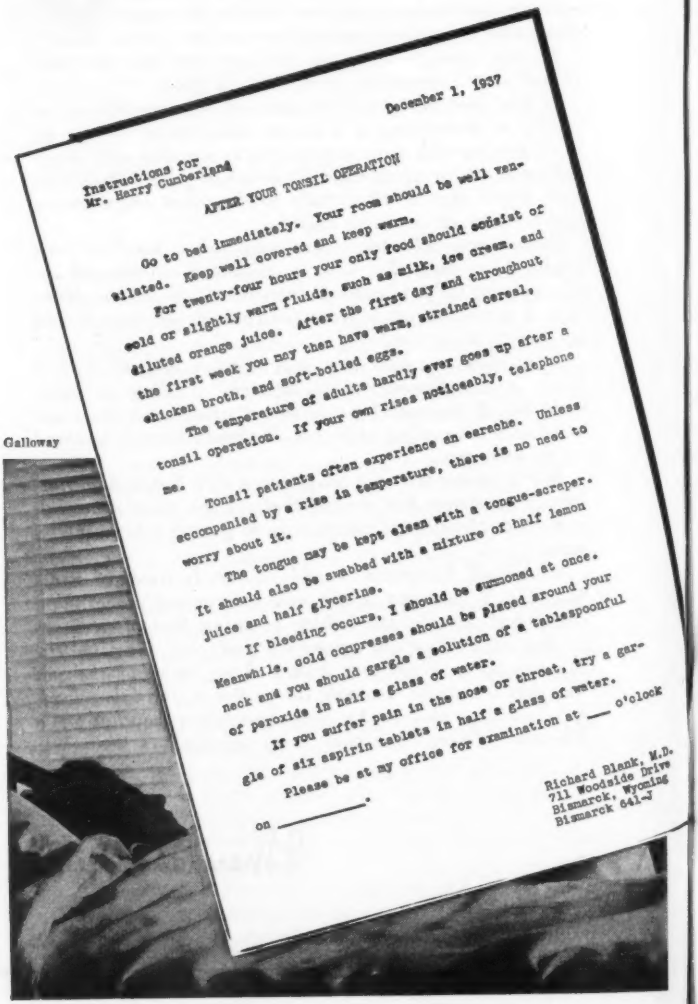
It is well to spurn any organization aligned with a labor group, however philanthropic-sounding its name may be. A successful professional association does not need such entangling alliances. It should be able to stand on its own feet.

Work toward friendly cooperation *with hospital authorities. Experience has proved that it's the most practical, as well as the most pleasant, way of getting whatever you want.*

Above all, beware the rabble-rouser. In times of stress like this, he turns up in the most unexpected places. You can detect him by the hidden meaning that often lurks in his most idealistic promises and that may be the boomerang to dash your hopes. Keep in mind the sad fact that for all he may talk like a Bacon, the labor leader's working philosophy may sometimes be that of a Barnum: "There's one born every minute."

H Sheridan Baketel

PUT IT IN WRITING!



December 1, 1937

Instructions for
Mr. Harry Cumberland

AFTER YOUR TONSIL OPERATION

Go to bed immediately. Your room should be well ventilated. Keep well covered and keep warm.

For twenty-four hours your only food should consist of cold or slightly warm fluids, such as milk, ice cream, and diluted orange juice. After the first day and throughout the first week you may then have warm, strained cereal, chicken broth, and soft-boiled eggs.

The temperature of adults hardly ever goes up after a tonsil operation. If your own rises noticeably, telephone me.

Tonsil patients often experience an earache. Unless accompanied by a rise in temperature, there is no need to worry about it.

The tongue may be kept clean with a tongue-scraper. It should also be swabbed with a mixture of half lemon juice and half glycerine.

If bleeding occurs, I should be summoned at once. Meanwhile, cold compresses should be placed around your neck and you should gargle a solution of a tablespoonful of peroxide in half a glass of water.

If you suffer pain in the nose or throat, try a gargle of six aspirin tablets in half a glass of water.

Please be at my office for examination at ___ o'clock on _____.

Richard Blank, M.D.
711 Woodside Drive
Bismarck, Wyoming
Bismarck 641-J

Galloway

BY GEORGE D. WOLF, M.D.

Oral instructions to patients are not enough, says Dr. Wolf. Crystallize them in writing, he advises, so that they won't be misunderstood. So many cases require almost identical instructions that the author has prepared a number of useful forms for daily use. Seven of them are reproduced with this article. If you'd like to see others published, let us know. Dr. Wolf is the author of a new book on medical economics, scheduled for early publication by the J. B. Lippincott Company.

WITH A SMILE of reassurance, I adjusted my stethoscope. What I heard erased the smile in a second. I could hardly believe my ears. Why, the baby's heart was pounding like a trip-hammer.

A bit shaken, I turned to the young mother. "Did you follow my instructions?"

Her face flushed as she replied:

"Well, I couldn't remember the exact amount. It seemed to me you said to give him a teaspoonful of the medicine three times a day. So that's what I did."

"A teaspoonful!" I threw up my hands. "Good Lord, that's enough for a *dozen* babies. I said *three drops*."

As I drove back to the office, the mother's words rang in my mind: "I couldn't remember...It seemed to me..."

"Imagine simple directions like those causing so much trouble," I muttered to myself. I couldn't forget the way that poor youngster's heart had thumped in my ears. A few more teaspoonfuls like that and—who knows?

That night I made a resolution. It was one that may profitably be repeated, I believe, by every private practitioner. I determined that in the future I would *write out all instructions to patients.*

For patients are only human. Sometimes a woman will nod her head—apparently in perfect understanding—as the physician outlines his course of treatment. Then when she gets home the trouble begins. She discovers that she has only the foggiest notion of what the doctor was talking about.

Rather than confess to ignorance by phoning the office, she omits the treatment altogether, thus wasting both the physician's advice and her money. Or, like the young mother referred to, she may guess—with perhaps hazardous results.

Unfortunately, in such cases, it is the doctor who gets the blame. Failure to understand instructions or to remember them breeds dissatisfied patients. And dissatisfied patients simply don't return a second time.

That's why it pays not to depend

entirely upon word-of-mouth advice. Supplement it with a typewritten sheet of instructions. Not only does this carry more weight with the patient and help insure the successful outcome of the case, but it is also a great help to the physician. It eliminates frantic post-visit telephone calls. It does away with tiresome repetition of directions. And your carbon copy is a handy reminder of what recommendations you made during the last visit.

At this point a word of caution: Don't have your instruction forms *printed*. If you do, they'll lose their personal touch.

The chief disadvantage of any form is its tendency to submerge the individual. To avoid this, it should be written with utmost care. Choose words that express your own personality. Don't try to sound *too* professional. Converse naturally.

The patient must be made to understand, of course, that he is receiving the *individual* remedy demanded by his particular case. This can be done by prefacing the written instructions with a brief, verbal comment. Something like this:

"I'm sure you realize, Mrs. Phelps, that the successful outcome of this case depends on your close cooperation. For that reason, I want you to make a special effort to follow my instructions carefully. So that you won't forget them or misunderstand them, I am going to give you a *typed* list of instructions to take home with you."

Forms used in my own practice are typed by my secretary from a variety of master forms which I personally wrote some time ago and which I revise whenever it seems advisable. If it becomes necessary in any case to deviate from the master form, I naturally tell my secretary beforehand what changes or additions are to be made.

Every instruction sheet, after being typed, should be checked by both the physician and the typist. This takes only a moment and spares you the possible embarrassment of having some woman patient, for example, hand you back an instruction sheet which contains a caution about not chewing tobacco.

No instruction sheet should be allowed to leave the office if it includes any controversial advice. Most of us have our pet ideas about the value of certain treatments. But when we commit ouselves in black-and-white, it's good policy to give advice about which there can be no question. After all, the patient *may* show the form to some other doctor; and if his theory differs from yours, well. . . .

The instruction forms I use all bear my name, address, and telephone number. Thus, the patient knows at a glance who gave him the instructions and can reach me in a hurry without having to look up my phone number or address.

On each form the patient's name is also typed, together with the date on which the instructions were given. Not that these last are especially important. But they do contribute to that all-important feeling of the patient that he is getting an individual prescription.

A complete sample instruction sheet is illustrated on page 42. Six other forms which I have used successfully follow.

To save space, only the title and

body of each form are quoted. The patient's name, date, and my name, address, and telephone number have in each instance been omitted.

Obviously, the instructions suggested can and should be modified to suit your particular needs. They are intended merely as general guides.

SINUSITIS

Successful treatment of this disease depends largely on your willingness to help yourself. I can give you these directions. But it is up to you to carry them out. If they are followed faithfully, they will help to improve your condition and may protect you against future attacks.

Don't go outdoors with damp hair. Beware of drafts. Avoid chilling the body. Don't pass from a warm room to a cold one, or take iced drinks when overheated.

If you become overtired, your resistance is lowered. This may result in a relapse, even after you are supposedly recovered. So avoid overwork.

Don't walk on cold floors in your bare feet. Keep your slippers near your bed. When you go out on

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TWO-IN-ONE OFFICE

MY PROBLEM was one of space. I had a single room, 18′ x 12′, as an office. I needed both consultation and examining chambers.

What to do?

Obviously, divide the room.

But how?

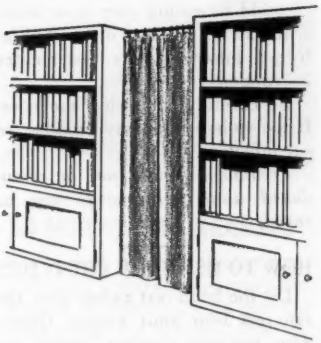
With bookcases.

A carpenter built two for me. Each is 7′ high, 5′ wide, and 1′ deep. They extend from the middle of each long wall toward the center of the room. This splits the room into two equal sections.

Each bookcase is fitted with a chromium bracket. This is screwed into the top of its medial end. A chromium pipe, 1½″ in diameter, is supported by these brackets. From it hangs a colored curtain.

This completes the separation partially effected by the bookcases. When the curtain is drawn, the patient may disrobe with a great deal more privacy and room than screens allow.

The bookcase bases are really cabinets. Their hinged doors open out. These compartments are handy for storage.



A room thus divided has both utility and dignity. Its cost depends on the wood used. My bookshelves are oak. Including brackets, pipe, and curtain, they cost only $25.—EMANUEL J. RICHTER, M.D., New York City.

rainy days, wear rubbers and a rain-coat.

Bathing is permissible. But don't lie around the beach if the day is cool. Don't remain in the water until you begin to shiver. Above all don't do any diving.

Always wear a hat out of doors. Wear heavy underwear in cold weather (wool or a wool mixture, is best).

Eat only easily-digested foods. Include plenty of fresh fruit, vegetables, milk, and eggs. Avoid overloading the stomach. Keep your bowels open.

Try not to worry. Take good care of your skin, stomach, and teeth. They are important factors in your condition. Poor general health often contributes to sinus trouble.

If you must drink and smoke, be moderate. If possible, don't do either.

Avoid irrigating your nose indiscriminately. It may drive the infection into your ears. See me for instructions.

Be careful in blowing the nose. If too violent, this may produce an ear infection.

Treatment should not be abandoned until I discharge you as cured.

HOW TO USE YOUR CRUTCHES

Let the hand-rest rather than the arm-rest bear your weight. Otherwise, you may develop "crutch paralysis."

The crutches should be about four inches ahead of the body when you are standing or getting ready to walk. The body should play the part of a third leg.

To walk, lead with the right crutch. Bring the right foot up just short of the crutch. Move the left crutch forward. Follow with the left foot. Repeat.

HOW TO MAKE A MUSTARD PLASTER

The ingredients for an adult are two tablespoonfuls of powdered mustard and seven tablespoonfuls of flour. Tepid water is added and stirred until a paste forms. It should be smooth, without lumps, and have a strong mustard odor. If this odor is lacking, the mixture is useless.

You will also need four cloth squares. They should be the size of a man's handkerchief. Sheeting, flannel, or cheesecloth will do nicely.

With these cloth squares make two "sandwiches," each with a paste filling. That gives you one plaster for the chest and another for the back.

Before applying the plasters the skin must be protected with yellow vaseline. Women should also cover the nipples with absorbent cotton. Both plasters should be applied simultaneously.

The patient should rest on his side. In that way, the plasters can be frequently examined. When the

skin begins to redden, it is time for their removal. No washing immediately is advisable.

Warning: The plasters should not leak or be left on until the skin burns.

ENEMIES OF YOUR BABY'S HEALTH

1. Pacifiers and coughers.
2. Thumb- or empty-bottle sucking.
3. A pillow in the crib.
4. Foods not in the regular diet.
5. Kissing, especially on the mouth and hands.
6. Too much, or irregular, feeding.
7. Rubber pants, except as a temporary measure.
8. "Cleaning" of the face with a spit-dampened handkerchief.
9. Letting the baby sleep in your bed or while nursing.
10. Using your mouth as a guide to the temperature of the bottle.
11. Biting or tearing the baby's finger and toe nails.
12. Washing the baby's mouth.

BEFORE YOUR TONSIL OPERATION

The day before the operation, an enema should be given. Avoid physics; they sap the body of needed fluid.

Bring with you a bathrobe, slippers, and two pairs of pajamas.

A local anesthetic will be given. So breakfast on liquids and soft foods. Drink as much fluid as possible; it helps prevent thirst after the operation.

[NOTE: *If a general anesthetic is to be given, use the following as a substitute for the last paragraph above:* A general anesthetic will be given. So don't drink fluids for three hours before the operation. The stomach needs that much time to eliminate them.]

SYPHILIS

In this disease the blood stream is infected. As a result, your cure may take two years or more.

If symptoms disappear after a few weeks of care, *don't conclude that you are well. Treatment must be continued long after all signs of the disease have vanished.*

Don't fail to obey my orders. If allowed to progress unchecked, your ailment may permanently injure your brain, blood vessels, heart, nerves, liver, bones, eyes, and other organs.

What to Do

1. Use only the treatment prescribed.
2. Drink lots of water.
3. Confine your diet to easily-digested foods.
4. See that your bowels move regularly.
5. Sleep eight hours a day and by yourself.
6. Bathe often and keep clean.
7. Brush your teeth twice a day and see your dentist every two

IRON both pleasant and efficient

Tasteless

Odorless

Non-Staining

Non-Constipating

Non-Irritating

The patient's cooperation has much to do with the results of iron feeding especially since most iron preparations are so unpleasant both in taste and in gastro-intestinal effects. The less desirable after-effects of the simpler ferric salts are not eliminated by iron compounds or capsules which simply mask the taste. Nor are such forms of iron always efficiently absorbed—especially if the patient's cooperation is lacking over the necessary feeding period.

OVOFERRIN is simply iron in its most minute, most efficient subdivision. Its protective protein colloid renders it tasteless, odorless, non-staining and non-irritating to even the most sensitive convalescent. OVOFERRIN reaches the small intestine still in its highly subdivided colloidal state, in proper form for ready and efficient assimilation. It is a rapid blood-builder, pleasant to take and a flexible vehicle when necessary. Prescribed in 11-ounce bottles. Samples gratis to physicians.

A. C. BARNES COMPANY, INC.

New Brunswick, N. J.

"Ovoferrin" is a registered trade-mark, the property of A. C. Barnes Co., Inc.

months. (When you do, tell him of the disease so he will sterilize his instruments thoroughly.)

8. Keep up your treatments faithfully until I discharge you. Do so even though you are apparently all right. *Remember, you have not been cured until a blood test shows it.*
9. Use only your own soap, washcloth, hairbrush, razor and towels (paper ones are best).
10. Burn all dressings used on open sores.
11. Cover toilet seats, both public and your own, with paper.
12. Eat off dishes that are kept separate from those used by your family. Paper utensils are preferable.
13. If you consult another doctor, inform him of your previous treatment.
14. After your discharge, have a blood test made twice a year.

What Not to Do

1. Don't kiss anyone.
2. Don't marry until I pronounce you cured. Through sexual relations, you would probably infect your wife. Moreover, any children resulting from such a union would be likely to inherit the disease.
3. Don't use tobacco until I approve it.
4. Don't drink alcoholic beverages.
5. Don't eat spicy foods, such as mustard, pickles, and pepper.
6. Don't worry or exert yourself unnecessarily.
7. Don't use a toothbrush that has stiff bristles.
8. Don't patronize public restaurants.
9. Don't follow the advice of quacks, or even of well-intentioned friends. There is no short-cut cure for your disease.

The above precautions must be observed not only for your own sake but for the protection of others as well. Your disease can easily and unintentionally be transmitted—especially to those with whom you live. *In the eyes of the law, you are a criminal if you spread this disease through negligence. You can be prosecuted.* So follow these instructions to the best of your ability.

CHIMES CALM CALLERS

IT'S THE LITTLE THINGS that smooth the doctor-patient relationship. So, in office planning, why not consider twin chimes instead of a piercing doorbell?

When the outside button to my office is pressed, chimes strike a mellow note. As the door closes or the button is released, a deeper, harmonious tone sounds. Simple as this device is, it adds a restful air about which many patients have remarked.—BERNARD A. SNESAVAGE, M.D., Tower City, Pa.

Symptoms Complex . . . X-ray Evidence Specific

ONE of the most difficult problems when ulcers of the stomach or duodenum are suspected is to definitely prove that the condition exists. Disturbances of other abdominal viscera may present similar symptoms, so the primary task is one of differentiation.

In the majority of cases where ulcers are present, radiographic examination will reveal specific evidence of them . . . establish their type and location . . . indicate their state of activity. X-ray study of the intestines and gall-bladder will rule out or confirm disease of those organs as a coexistent factor. Radiographs made following treatment will disclose whether satisfactory functional activity has been re-established . . . whether the condition has recurred or a new complication has arisen.

As soon as gastric or duodenal ulcers are suspected, and during management of the case, your radiologist's service is practically indispensable. Eastman Kodak Co., *Medical Division*, Rochester, N. Y.

RADIOGRAPHS PROVIDE DIAGNOSTIC FACTS

SUBSIDIES FOR MEDICINE?

A bloodless revolution is going on within the profession. On one side are officials of the A.M.A. in Chicago. On the other side are 430 of the nation's leading medical men, banded into a Committee of Physicians. The latter group have signed a document which threatens to make medical history. It is dedicated to the proposition that "the health of the people is a direct concern of the government." Here's an appraisal of this latest rift, written specifically for the private practitioner who asks: "How will it affect ME?"

THE QUESTION of government subsidies for medicine split American medical ranks wide open last month as 430 of the country's outstanding doctors, organized into a Committee of Physicians, revealed that they had signed a sweeping declaration of medical independence. Their manifesto recommends the allocation of public funds for medical care of the indigent, for research work, and for medical education. It was released in the face of direct opposition by the American Medical Association, whose House of Delegates overwhelmingly rejected a similar set of proposals last June.

The attitude of A.M.A. officials, held responsible in part for the break, were summed up by one of its spokesman in a letter published in the New York *Times* on November 7, the date of the declaration's appearance. Said he:

"The House of Delegates of the American Medical Association has consistently objected to federal subsidies of this character. Such subsidies are never given without approval in Washington of the manner in which the funds are to be used, thus putting the government directly in control of medical education and medical practice."

The A.M.A. is not entirely alone in the foregoing point of view. It is held also by a segment of the profession which operates on the theory that "it's better to be safe than sorry." Physicians who think along this line ask, for example: "How can public funds be appropriated for indigent care without inviting political skullduggery and undue government intervention in medicine?"

That's one of several major problems to which the Committee of Physicians admits frankly that it has found no solution. It is working toward a solution, however, and hopes to evolve one in time.

That such questions loom large in the minds of many of the 430 doctors is avowed even by Dr. Russell L. Cecil, committee chairman. Asked for his opinion, he confessed:

"Some of the leaders in the pro-

fession—some of my best friends—think there is a certain danger of political chicanery. They have jumped on me verbally for backing such a plan."

However the "declaration of independence" may have reacted on physicians, its release was music to the ears of a large section of the lay public. This point was emphasized in the New York *Herald-Tribune,* which, on November 8, observed editorially:

"If those elements in a city's population who live under the least healthful conditions are discouraged from seeking free medical care, they are certain to incubate and spread diseases which may readily be a heavier tax upon the public purse than any amount of subsidized doctoring could be... A little doctoring would in many cases forestall a lot of charity. One breadwinner's neglected injury or illness, which could be cheaply doctored, often reduces a whole family to permanent dependence on public charity."

The doctrine on which the committee's declaration is based had its roots in *American Medicine: Expert Testimony Out of Court,* the two-volume, 1,500-page report on medical practice published last April by the American Foundation. This survey, it will be recalled, quoted from the letters of 2,100 physicians. It made no recommendations.

But rumors of what finally happened last month have been in the air ever since the report's issuance. Immediately afterward, a conference of medical and allied groups was held in New York City. A number of those who attended later visited Washington to sound out President Roosevelt. The result of their discussion was a set of resolutions almost identical with those subscribed to by the present Committee of Physicians. Adopted formally by the House of Delegates of the New York State Medical Society, these resolutions were then introduced at the annual meeting of the A.M.A. House of Delegates at Atlantic City in June. After a bitter battle, they went down to ignominious defeat.

The American Foundation so far has not given its name to the child which it actually fathered. Nevertheless, it is known that the foundation is cooperating closely with the Committee of Physicians.

Meanwhile, a flood of congratulatory messages is reported descending upon the committee. Up

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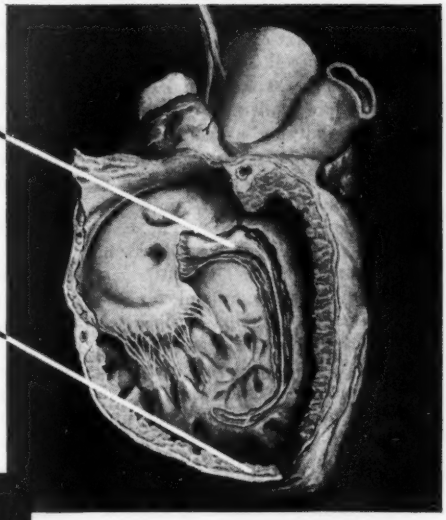

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to his ears in letters and telegrams, Dr. John P. Peters, secretary, told MEDICAL ECONOMICS that the bulk of these are favorable to the expressed aims of the movement. Chairman Cecil's opinion, on the other hand, was modified. He said he was not under any misapprehension that the proposals would receive the blanket support of the profession. According to him, it is just a matter of time until the opposition organizes.

"I'll probably get some kicks in the pants, too," he sighed.

There is some ground for the chairman's restrained outlook. A flame of resentment is being fanned by the fact that many of the pronunciamento's signers are health officers, public officials, and professors whose income is not dependent upon private practice. Representative of this brand of criticism is the following typification of the committee's personnel:

"They are mainly college professors, not practicing medicine, not faced with making a living. Naturally they favor a government subsidy to the poor class and the white-collar class. In neither case would their income be touched. But if the government subsidizes the white-collar class, the doctor's chief source of income will be cut off."

Health officials tend to hedge. Dr. George S. C. Ruhland, health officer of the District of Columbia, termed the nine-point program "excellent in principle." But, he added cautiously: "How far to carry it, and under what system, is extremely controversial." Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, affected to be puzzled. "I don't know what all the fuss is about," he insisted. On the matter of the existing gulf between the physicians' committee and the A.M.A., however, he talked freely. He denied that the committeemen were rebels, hinting that the shoe was on the other foot. Said he:

"The revolt is on the part of the A.M.A. The principles we advocate have long been recognized. Disraeli, the British prime minister, espoused the concern of government for the people's health. The principles and proposals seem very conservative and sound."

The proposals may well be as sound as Dr. Parran is convinced they are. But the vision of portentous clouds on the horizon persists in the minds of many private practitioners. Bureaucracy, log-rolling,

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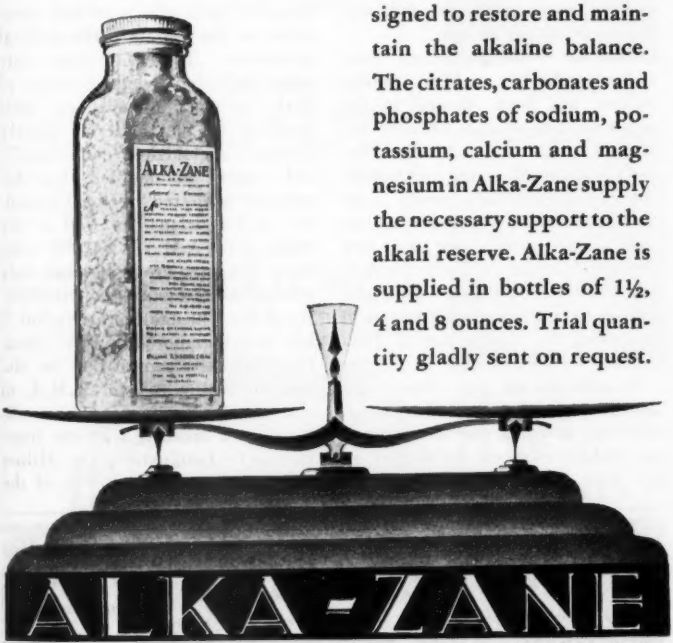

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patronage—all the familiar hobgoblins associated with government control—are gloomily predicted as lying in the offing.

Fear of contributing to the chaos may have impelled Washington to preserve its present policy of "watchful waiting." The real attitude of the White House is said to be reflected in the address of Josephine Roche, Assistant Secretary of the Treasury in charge of public health, before the American Public Health Association during October. Miss Roche recommended formation of a "special committee to cooperate with the United States Public Health Service in extending through proper methods the long-accepted functions of public health work to meet modern demands and the needs of our people."

The war of the physicians' committee with the A.M.A. policy-makers has been likened to the contemporary struggle between the A.F. of L. and the C.I.O. for control of labor. It is an odd coincidence, too—although hardly more than that—that organized labor has come out strongly for the new body. Spokesmen of both the A.F. of L. and C.I.O. dropped their private duel last month and joined in endorsing the Committee of Physicians wholeheartedly.

At present, the gap seems to be broadening rather than decreasing. The very morning that the committee boldly snapped its fingers in the face of the A.M.A. the New York *Times* was quick to point out:

"There are indications that the open defiance of the authority of the association is spreading among many of the rank and file of American physicians who have been silently opposing the attitude of their leaders and have been waiting for prominent members in their ranks to take the initiative."

Two days later, on November 9, the *Times* continued in this vein by publishing the following communication from a layman, A. Ranger Tyler. Said he:

"The intransigent attitude of those in Dr. Fishbein's camp reveals an intolerance hardly befitting the high position of their profession...We need a restored confidence in those who represent themselves as the leaders of the medical profession...This can come only when they abandon their tactics of flatly refusing to evaluate their position in the light of vastly changed sociological conditions."

It cannot be doubted that this attitude is shared by the Committee of Physicians, as well as by many of the A.M.A.'s 100,000 members. The new group has not only refused to recognize the infallibility of the Chicago hierarchy but it has calmly ignored it. The situation was only aggravated by the attempt of the *Journal A.M.A.* to stem the tide with a sarcastic editorial bull unleashed at the innovators. In indignation, Dr. Milton C. Winternitz, former dean of the

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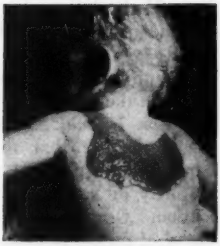
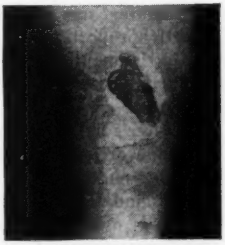


BURNS



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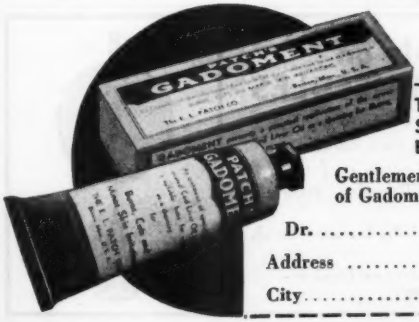

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Yale Medical School, retorted:

"The principles and proposals stand for themselves. They have been subject to gross misinterpretation in the *American Medical Association Journal*. . .It is not possible to believe that this editorial expresses the point of view of the majority of members of the Association. . .Our committee is composed of members of the American Medical Association. Their allegiance to the association, as that of its thinking membership, will be directly proportionate to the leadership it manifests in the great national health problems."

Another A.M.A. thorn in the committee's side was the statement by Dr. Morris Fishbein that "unthinking endorsers of the American Foundation's principles and proposals owe the medical profession some prompt disclaimers." Few, if any, such disclaimers have been received. The remark brought only the quiet confidant rejoinder from Chairman Cecil that:

"I don't think the American Medical Association should try to muzzle a minority group. The A.M.A. has been pretending that there is no problem here at all. We know very well that there is."

If the committee, as its chairman modestly suggests, is a minority one, its individual components are strong in background and reputation. Physicians in every branch of practice and from all parts of the country are represented. For example: Drs. George R. Minot, Nobel Laureate in Medicine in 1934; Ernest B. Bradley, retiring president of the American College of Physicians; Evarts A. Graham, president of the American Surgical Association and head of the newly-formed American Board of Surgery; Frederick C. Kidner, president of the American Orthopedic Association; A. Graeme Mitchell, of the National Board of Medical Examiners; Borden S. Veeder, president of the American Board of Pediatrics; Charles S. Burwell, dean of Harvard Medical School; George H. Whipple, of the University of Rochester (N. Y.); Thomas Parran, Surgeon General of the U. S. Public Health Service; Edward S. Godfrey, New York State Commissioner of Health.

As yet, the approval of these men, and others like them, has been the mainspring of the movement. Further action will depend on a meeting held a fortnight after the release of the declaration.

Crystallization of the problem of

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medical indigency was presaged by MEDICAL ECONOMICS last April. At that time, it urged "provision of medical care for the indigent, on a sound permanent basis, with fair compensation for professional services rendered." It emphasized that "This is no argument for compulsory health insurance. Quite the contrary. Health insurance fails completely to provide for the unemployed and the unemployable, who are most in need of aid." An editorial in the May issue added:

"The assumption that governmental participation in medicine is inevitable may readily be challenged. If, however, we assume that it *is* inevitable, the responsibility falls on medicine of urging a strictly *limited* form of participation under which only those services rendered to the medically indigent would be paid for out of tax funds. A subsidy of this kind, *under proper control*, would seem indeed to have a number of definite advantages... Gratuitous service to the poor is a tradition in medicine. Private physicians give of their time and skill gladly. But they cannot do the impossible. The weight of charity service is growing to such an extent that some practitioners do not receive even a subsistence income. Society *must* help absorb the cost of caring for the indigent sick."

The text of the declaration signed by the 430 medical men and now presented to the medical organizations for consideration, follows:

PRINCIPLES

1. That the health of the people is a direct concern of the government.
2. That a national public health policy directed toward all groups of the population should be formulated.
3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their solution.
4. That in the provision of adequate medical care for the population four agencies are concerned: voluntary agencies, local, state and federal governments.

PROPOSALS

1. That the first necessary step toward the realization of the above principles is to minimize the risk of illness by prevention.
2. That an immediate problem is provision of adequate medical care for the medically indigent, the cost to be met from public funds (local and/or state and/or federal).
3. That public funds should be made available for the support of medical education and for studies, investigations and procedures for raising the standards of medical practice. If this is not provided for, the provision of adequate medical care may prove impossible.
4. That public funds should be available for medical research as essential for high standards of practice

THE THIRD TRIP TO THE ARCTIC CIRCLE

The picture below shows Dr. Knight applying BAYHESIVE to the wrist of one of the members of Robert A. Bartlett's West Greenland Expedition of 1937 organized under the auspices of the Smithsonian Institution and the Chicago Zoological Society. This makes the third time that Bay's Surgical Dressings have gone on this trip to the Arctic Circle, the other two having been in 1935 and 1936.

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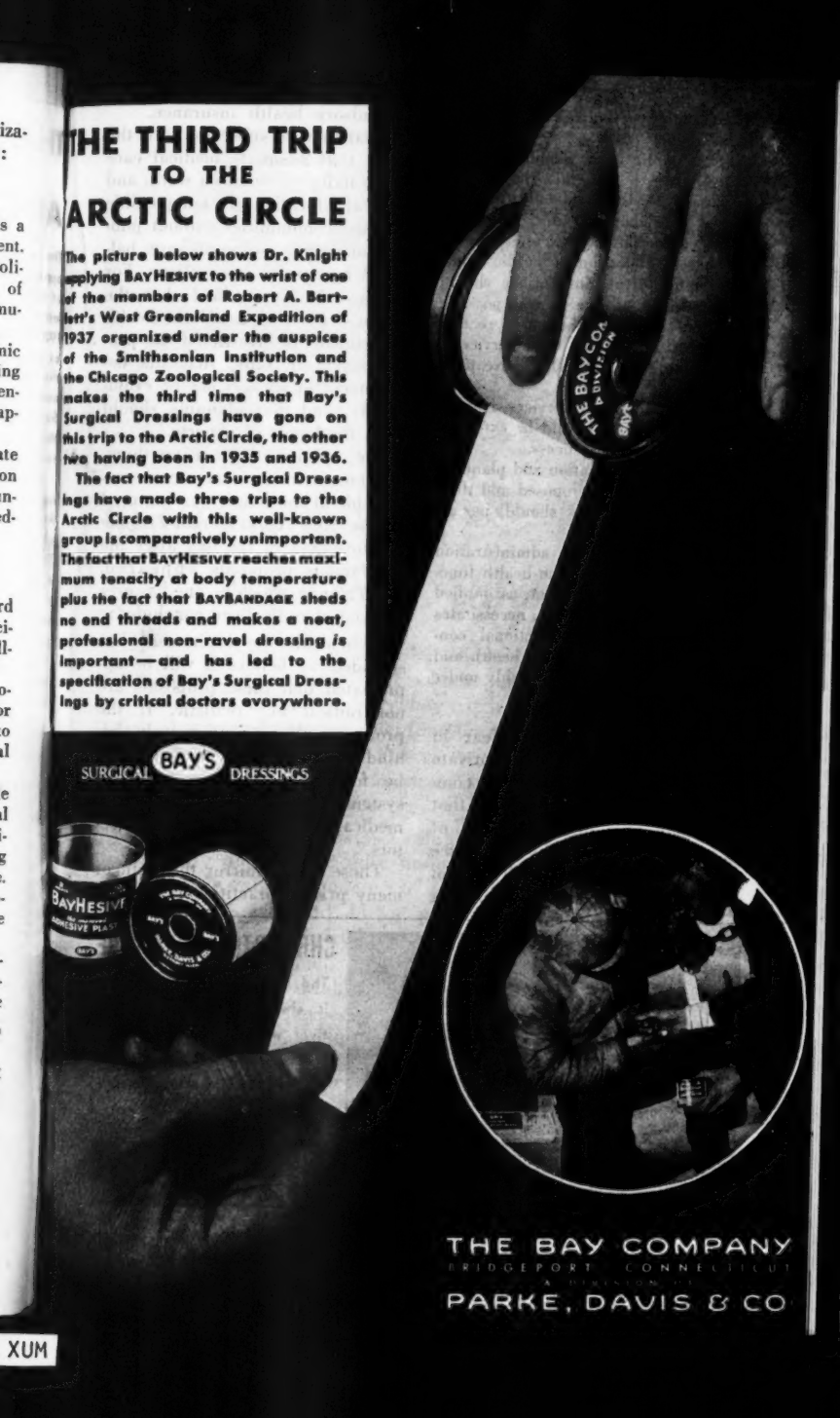

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in both preventive and curative medicine.

5. That public funds should be made available to hospitals that render service to the medically indigent and for laboratory and diagnostic and consultative services.
6. That in allocation of public funds existing private institutions should be utilized to the largest possible extent and that they may receive support so long as their service is in consonance with the above principles.
7. That public health services, federal, state and local, should be extended by evolutionary process.
8. That the investigation and planning of the measures proposed and their ultimate direction should be assigned to experts.
9. That the adequate administration and supervision of the health functions of the government, as implied in the above proposals, necessitates in our opinion a functional consolidation of all federal health and medical activities, preferably under a separate department.

Perhaps the dominant fear in the mind of the average private practitioner concerning the committee and its proposals is that they may turn into some sort of radical boomerang. The committee stresses, however, that it is not campaigning for state medicine or compulsory health insurance.

What they do subscribe to is the belief that adequate medical care of the indigent, research work, and medical education are not possible in many communities without public aid. Their proposals are balanced by careful reservations. For instance, it is specified that the administration of a federal health department be restricted to professional men only, that the development of its services be evolutionary, and that planning should be in the hands of experts.

The opinion that, if anything, the committee sits on the conservative side of the fence, was ventured by the New York *Herald-Tribune* on November 8, the day after the now-famous proposals appeared. The *Tribune*, which no one has ever accused of radicalism, concluded:

"When all the excitement has subsided we believe it will be appreciated that these proposals are not radical but realistic. If the profession lines up squarely behind them, socialized medicine can be forestalled by a conservative system of subsidies to adequate medical care and directed by doctors."

Those words mirror the faith of many private practitioners.

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Cream of Wheat is a valuable energy food, easily digested, rapidly assimilated. Its high calorific value is made up of 72.5% carbohydrate, 2.4% fat, and 11.8% protein. This preponderance of carbohydrate, and the ready release of its contained fuel energy, give to Cream of Wheat a valuable place on the breakfast menu, valuable especially for children. In addition, Cream of Wheat is remarkably reasonable in cost; a generous serving costs less than half a cent.

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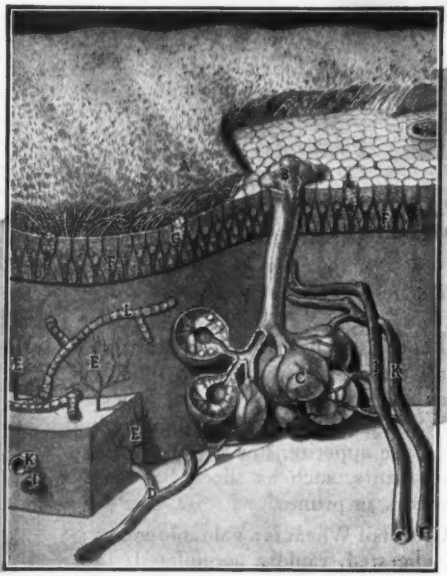


A—Cilia. B—Mucous secretion exuding from gland orifice. C—Gland composed of mucous and serous cells. D—Nerve bundle. E—Arborization of nerve ends.

F—Epithelium (pseudo-stratified columnar). G—Goblet cell discharging mucus. H—Orifice of another gland. I—Artery. K—Vein. L—Lymph vessel.

SCHEMATIC REPRODUCTION OF BRONCHIAL WALL

PERTUSSIN—saccharated extract of thyme—provides unusually effective cough therapy through its desirable fourfold pharmacodynamic action.

Increases Secretion of Thin, Soothing Mucus

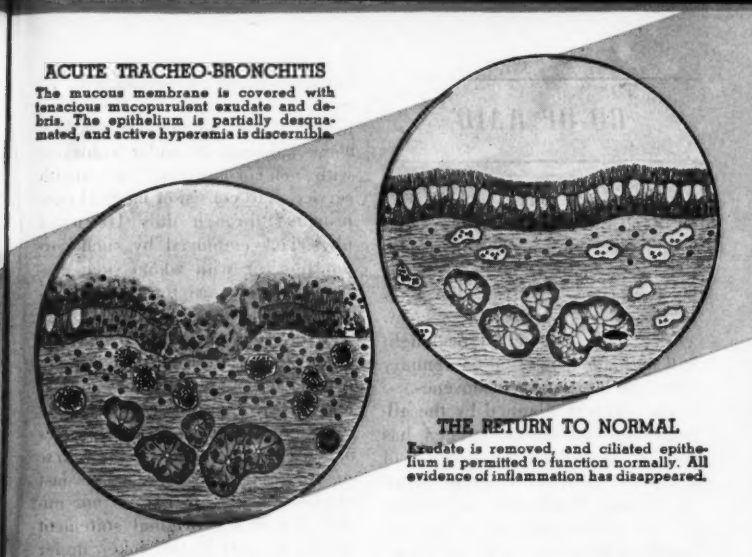
By direct action upon the secreto-motor center in the medulla, Pertussin provokes the secretion of thin, protective mucus. Undue dryness in the respiratory mucosa is overcome, lessening unproductive hacking cough and overcoming the burning sensation in the trachea.

Liquefies Tenacious Phlegm, Making Cough Productive

Since its therapeutic ingredient is excreted by the glands of the trachea and bronchi, tenacious hard-to-dislodge secretions are rendered more liquid and easier to expel. Coughing is thus made productive.

Lessens Frequency and Severity of Cough Seizures

Pertussin exerts a mild but well-defined sedative influence upon the cough reflex. The sensation of laryngeal irritation is less impressed upon



ACUTE TRACHEO-BRONCHITIS

The mucous membrane is covered with tenacious mucopurulent exudate and debris. The epithelium is partially desquamated, and active hyperemia is discernible.

THE RETURN TO NORMAL

Exudate is removed, and ciliated epithelium is permitted to function normally. All evidence of inflammation has disappeared.

the consciousness, and the frequency and severity of cough seizures are reduced. Productive coughing is not interfered with.

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Because Pertussin overcomes undue dryness in the respiratory mucosa, and because blanketing, tenacious mucus is removed, protective ciliary activity is restored. The valuable sweeping-out action of the cilia aids expectoration and contributes to resolution.

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Since Pertussin combines the four pharmacodynamic actions essential for dependable cough therapy, its clinical influence is prompt and highly effective. The "tight" cough becomes productive, exhausting paroxysms are reduced in frequency, and recovery is hastened. Pertussin has proved of excellent value in acute tracheobronchitis; the cough of influenza, rhinitis and other respiratory infections; chronic bronchitis, bronchiectasis, asthma; whooping cough.

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CO-OP RAID

TURNED AWAY when they knocked on the front door of the medical profession, the consumer cooperatives are now trying to break in the back entrance. This time the gates to be stormed are those of New York State. The actual onslaught will be made some time in January when the legislature reconvenes.

The strategy planned by the all-for-one-and-one-for-all forces has come to light with the issuance of a revised New York State insurance code. While this is the first revision of the law in 75 years, it hardly makes front-page news alone. What *is* significant is this:

The law takes up 537 pages of extremely uninteresting reading. But buried on page 279 of a volume hardly likely to come to the attention of physicians is some startling information.

There, under the heading, "Article IX-C," is a matter-of-fact description of a proposed law governing "non-profit health service or hospital service corporations." The text reads, in part:

"A consumers' cooperative stock corporation may be organized . . . for the sole purpose of furnishing health service to persons who become subscribers under contracts with such corporations. Such health service shall consist of medical care provided through duly licensed physicians employed by such corporation, or with whom such corporation contracts for the furnishing of such care."

The service, it is added, may include "hospitalization and nursing care, drugs and medicines, optical and surgical appliances, and *any other medical and surgical services and supplies necessary in the course of such medical care.*" The last clause, needless to say, is *not* underlined in the original statement of the law. It is the joker under which medical co-ops would shortly be licensed to perform any of the duties of private physicians.

Only if the reader goes on to the next page does he discover that legalization of medical co-ops is at all an innovation. Tersely labeled "comment," and printed in extremely fine type is this apology:

"The provision for health service corporations is new, but is based in part upon the successful experience of non-profit hospital organizations.

[*Turn the page*]

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Hypochromic anemia is a common ailment among adolescents who find it difficult to cope with the new burden of menstruation. Neobovinine with Malt and Iron assists in regenerating the hemoglobin of the red blood cells in such cases . . . . . In addition to the liver principle, each 100 cc. of Neobovinine with Malt and Iron contains 510 milligrams of Iron in a quickly assimilable form . . . It is exceedingly palatable and easy to take.

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It is believed that health service corporations similarly organized and conducted will be successful in fulfilling a similar public need for economic, self-sustained health service."

This bit of co-op propaganda, inserted in a state government document, is unsigned. But in the foreword to the volume, Louis H. Pink, New York State's superintendent of insurance, hands most of the laurels for the work to Professor Edwin W. Patterson, of Columbia University. The revision was prepared with the "cooperation and leadership" of Professor Patterson, according to Mr. Pink.

In the same foreword, Mr. Pink comes out strongly for passage of the code, which at present is merely "tentative." Asserting that "Governor Lehman has given his approval and hearty cooperation," he appeals to "all interested in insurance to cooperate . . . in securing its enactment by the legislature."

He further implies that enactment of a New York State insurance law that approves medical co-ops will mean adoption of similar legislation on a national scale. Says he:

"It [the New York law] has, together with the Massachusetts code, formed the basis for most of the insurance laws throughout the United States."

Mr. Pink also discloses that the state legislature has appointed a committee to hold hearings on the proposed changes. These are scheduled for sometime before January. At these meetings, physicians will presumably be allowed to register their disapproval of the section legalizing co-ops.

Superintendent Pink invites comments on the suggested change. Doctors wishing to protest this threat to private practice, or who desire further information, can address Louis H. Pink at Room 717, 80 Centre Street, New York City.

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AFTER PERIODIC HEALTH EXAMINATIONS, it is a good plan to send a summary of findings, diagnosis, and recommendations to the patient *on a letterhead.* This emphasizes your name both in his mind and in the minds of potential patients to whom, as friends, he is likely to show your report.—BERNARD BERENSON, M.D., Everett, Wash.

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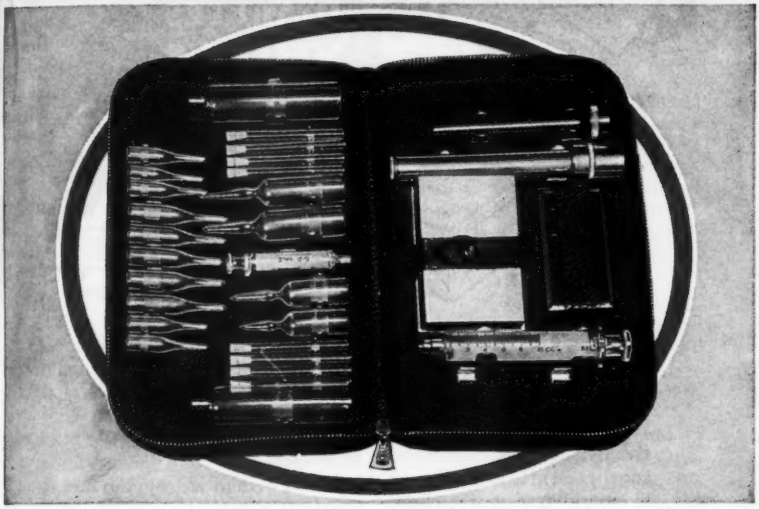

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No. 2502. Case complete with equipment including: Bakelite Syringe Sterilizer with 1 cc. B-D Yale Vaccine Syringe; Pocket Needle and Syringe Sterilizer with 2 cc. B-D Yale Luer-Lok Syringe and three B-D Yale Rustless Needles, 26G ½"; 10 cc. B-D Yale Luer-Lok Syringe; 2 cc. B-D Yale Syringe; Bakelite sundries box; eight No. 60 hypo tablet vials; two 8-drachm vials with Bakelite caps; stainless steel Needle Sterilizer Tray with twelve assorted B-D Yale Rustless Needles and clips for 1 cc. B-D Yale Tuberculin Syringe and fourteen ampoules.....$17.90

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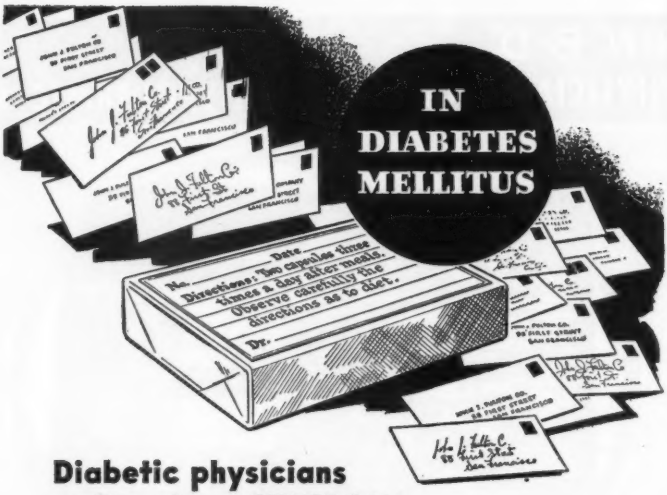

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BUILDING MEDICAL BUREAU MEMBERSHIP

★ By JOHN A. McGHEE ★

More and more physicians are banding together to establish medical business bureaus. Such bureaus have proved themselves indispensable for investigating patients' credit and expediting collections. Among the most successful are those in Youngstown, Akron, and Columbus, Ohio. Mr. McGhee organized the first two and assisted the sponsors of the third. At present he is executive director of the Medical Bureau of Pittsburgh, a newly-formed unit. This article is the second of a series written exclusively for readers of MEDICAL ECONOMICS.

A MEDICAL BUREAU is as strong as its leaders. In pioneering anything, a certain amount of apathy is always encountered. To overcome this requires persistence and hard work. Hence, the need for real ability among those who direct your membership drive.

Well-known members of the local society ought always to be drafted for this phase of the work. These men need not be at the apex scientifically, but they should be distinguished by activity in society affairs. Physicians who enjoy the confidence of the other members are of inestimable value in building membership.

Take care, too, in selecting your temporary chairman. He should have a contagious enthusiasm. Few organizations of this kind succeed without such a mentor.

Before the membership campaign gets under way, there's a preliminary financial problem to be solved. In the preceding article, you may recall, the structure of medical bureaus was considered. Funds for organization and office space were provided by an enrollment fee of $10. The question that comes up now is:

Do the enrollment fees provide sufficient capital?

The answer is definitely *no.*

This money will quickly be eaten up by the cost of publishing the prospectus and by other organizing expenses. Of course, as the membership grows, your resources will grow with it. But so will your overhead. There must be a steady source of income. Some medical bureaus have neglected this and are now out of existence.

Skeptics will bring up this argument:

Commercial agencies operate profitably on collection charges alone. Why can't medical bureaus do the same thing?

At first glance, this sounds reasonable. But actually, it isn't. Here is why:

Commercial agencies are usually financed by private capital. They have only one function. They can start with a desk and two chairs and expand gradually. Their com-

BAD-DEBT PREVENTION

MOST TROUBLE collecting fees can be eliminated in advance. I have made it a rule to allow no more than two office calls on credit. If there is no mention of payment after the second visit, I suggest a heart-to-heart talk with the patient. His bill and arrangements for future service are then discussed. This has done away with the annoyance of carrying accounts indefinitely from month to month and has helped collections tremendously. —GREGORY L. ENDRES, M.D., Midland, S. D.

mission rate is extremely high. They often remit no oftener than every three or four months. Thus, in their early stages, they can devote all cash collected to putting their business on a firm foundation.

With a medical bureau, it's different. It has many more functions than the single one of collecting. Yet its charges must be low. Therefore, until its commissions are sufficient to make it self-supporting, an assured income is essential. This is supplied by taxing each member $2 per month.

But, you may protest:

Won't monthly dues limit the membership?

To a certain extent, *yes.*

Some potential members will look upon a $10 enrollment fee as excessive. They will think the $24 for the first year's dues prohibitive. But they are the men unable to take a long-range view. Often, they can not understand why any dues are necessary at all.

Monthly assessments are essential to success. For one thing, they defray the cost of establishing and operating credit-rating files. They entitle the member to unlimited use of the service without extra charge. This will be discussed further in a later article. For the present, let us consider the monthly dues as absolutely necessary.

They have a secondary purpose, too. Members who do not use the bureau's facilities are apt to become disgruntled. They feel they are paying for something from which they derive no benefit. But the member who is compelled to pay a monthly fee is more likely to take advantage of the bureau's services. In this respect, it is advisable that the membership committee concentrate on selling the advantages of the bureau, rather than the cost of membership.

Charges based on operating cost alone are the ultimate ideal. But reductions should be confined exclusively to collection commissions, telephone rates, and other fees for specific services.

Monthly dues should *never* be tampered with. They furnish many psychological aids toward permanence. They keep the bureau out of direct competition with business

12 STRAINED FOODS *from the famous family of "57"*

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Heinz Strained Foods bear *both* the Seal of Acceptance of the American Medical Association's Council on Foods and the famous "57" Seal of Quality. That is why you are *doubly* safe in recommending them!

HEINZ STRAINED FOODS

agencies. They induce members to depend on the bureaus' services. This enables the bureau to extend its facilities to a point where many of them are truly unique.

The foregoing constitutes the groundwork of the membership campaign. Now for the campaign itself. We may start by inquiring:

What are the duties of the membership committee chairman?

His job is to organize and direct. He should be a real enthusiast. With the help of the sponsors, let him choose, say, ten assistants. These committeemen must be the type who will not spare any effort to make the drive a success. The chairman begins work as soon as some publicity has been obtained.

It may be recalled that a prospectus is to be printed. In small communities, it may be mimeographed. Before incurring this expense, however, it is well to augment the nucleus membership. This is accomplished at a special organization meeting. Invitations are sent to about fifty picked society members.

This is your first batch of potential members. See that it is thoroughly representative. Make sure that *all* local hospital staffs have delegates. Invite physicians from *every* section of the community. Limit the attendance to 75 at most. Too large a group is unwieldy.

Set a time that does not conflict with medical society functions, office routine, or hospital work. Hold the meeting in a central location. Ask officials of both medical and dental societies. Include a few dentists.

For the time being, it may be wise to omit the hospitals. They will be reluctant to support the venture anyway, until assured the cooperation of a substantial number of doctors.

Who presents the plan to the potential members?

This is a task for the most capable spokesman in the membership nucleus.

Other organizers should be prepared to back up his statements. Every effort must be made to control the meeting along favorable lines. Expect, however, some derogatory or unqualified objections.

Let it be understood that the plan is tentative. Point out that it may be adjusted to the needs of the membership. Emphasize the right of all to contribute toward the purposes and policies. Restrict any-

one who attempts to denounce the movement without knowledge of qualifications. Demonstrate its success in other communities. Explain that personal sentiment and impractical ideas have no place in the project.

When it looks propitious, call for membership enrollments. Pass out temporary membership agreements. These are forms stipulating the financial obligations, privileges, and terms of membership. (Suggestions for a permanent membership application will be offered in a subsequent article.)

Normally, a good percentage of those present will enroll on the spot. Appoint a temporary treasurer. Request all who can do so to pay their enrollment fees to him at once. Explain that the money is needed for organizing expenses.

Next, the meeting ought to be convened for members only. A temporary board of directors can then be chosen. They will conduct all business necessary to further the bureau. This includes securing a corporate charter and employing a business executive. Their number should be proportioned to the *potential* membership.

It has been found that the same proportion of local physicians and dentists will join the bureau as already belong to the local societies. It is best to regulate the size of the board to this future representation.

Promptly following the membership meeting the newly-elected directors should convene to elect officers. These are: president, vice-president, secretary, and treasurer. The membership committee chairman attends this meeting, even if he is not on the board. With the cooperation of the directors, he appoints the membership committee members.

The next query that arises is:

How are possible members solicited?

First, obtain a list of the members of the medical and dental societies. This is done by the membership chairman. He obtains the names from the secretary of each of these groups. Each committeeman is assigned ten society members from this list. He must contact these prospects.

It is a great convenience to note the name of each prospect on a 3″ x 5″ card. The committeemen ought to get, if possible, a *definite* reason from all who don't sign up. Their objections can be written di-

Linde makes freely available to hospitals and members of the medical profession up-to-date information on the technical and mechanical phases of oxygen therapy. A new booklet, "Handbook of Current Practices in Operating Oxygen Therapy Equipment," is now ready. Also available are reprints of many articles on oxygen therapy, and a Linde motion picture, "Current Practices in Operating Oxygen Therapy Equipment." Any Linde office will be glad to provide this literature or loan the film, without obligating you.

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rectly on their cards.

During the first month or two, the committee has to meet at least every ten days. At the second meeting, re-assign the cards of the hold-outs to other committeemen. The second solicitor will know what objections to expect. Therefore, he will be in a better position to meet the particular argument.

Follow this method until all but the most recalcitrant have signed up. Then repeat the process by distributing another set of cards.

This plan has proved very effective, especially in small communities. In large cities, the membership committees have to be rotated frequently. A committee is productive until it has exhausted the prospects among its immediate associates. The campaign is then spread to other fields by a brand-new committee. How often a committee ought to be changed depends on the individual case. It is impossible to fix a workable standard for every community.

The prospectus will materially reduce the work of the drive. After it has been approved by the board of directors, it is mailed to every member of the local societies. Enclose an application blank in each letter. And don't forget to include an envelope addressed to the bureau treasurer.

In some cities, a heavy membership has been built overnight solely through the prospectus. So don't fail to have a surplus supply of prospectuses. There are always those who throw away much of their mail without reading it.

The personal canvass by the membership committee should be withheld until a week after mailing the prospectus. It can then begin with solicitation of society members who are designated on the cards.

When the movement shows signs of progress, call up the local newspapers. Give them a *prepared* statement. In most communities, this is front-page news.

By the way, don't scorn publicity. It has many advantages. It creates interest among doctors who might otherwise not be reached. It educates the public to regard the movement as an ethical activity of the organized profession. It distinguishes the bureau from quasi-professional rivals. It often produces immediate payment of old accounts and current fees. Nor does it reflect unfavorably upon the motives of the members, as is sometimes feared. Laymen are often sur-

prised, in fact, to find that doctors have delayed economic organization of their practices so long.

Too much emphasis can not be placed on the need for concerted action. The basic principles of the movement must be thoroughly sold if it is to succeed. The advantages should be clearly defined and the membership committee chairman relentless in directing the drive. If a committeeman falls down on the job of contacting prospects, replace him. Don't tolerate apathy within your own organization.

Incidentally, no apologies are necessary for enrollment or membership fees. Most physicians understand that every cause, good or bad, requires money.

Keep in mind your one specific purpose: to create needed business services under cooperative control at rock-bottom cost.

Once established, the medical bureau will not eliminate the indigent and worthy poor. But it *will* segregate them from the wilfully negligent.

It will not place a credit rating above professional responsibility. But it *will* forewarn of questionable backgrounds.

It will not collect money where there is none. But it *will* induce payment of fees in proportion to ability to pay other accounts.

It will not serve as a complete adjustment of medicine to society. But it *does* represent a medium of progress in that direction.

"BOOTLEG" MEDICATION

A PATIENT had a dermatitis of the leg. His physician advised soaking it in a permanganate solution. Two weeks later the patient returned with the dermatitis healed. He had evolved this ingenious method of following the doctor's orders:

He had bought a pair of hip rubber boots. Slipping one on the affected leg, he poured it full of solution. Then he stood in it. He repeated this treatment, making up a fresh solution for each soaking.

It saved him considerable permanganate. A large amount would otherwise have been necessary to envelop the entire leg. This is especially convenient when an even more expensive solution is used.—J. W. NEPTUNE, M.D., Salina, Kansas.

INVESTORS' CLINIC

BY FRANK H. McCONNELL

... Depression or recession? ... Baby bonds: a triple bromide ... Forming your own investment trust ...

WHEN MARKETS BREAK wide open, the question invariably rises: "What's coming?"

Today every physician and every layman who has an eye on security quotations is looking for the answer.

In this connection, it is interesting to note that a majority of practical prognosticators are hopeful. True, they anticipate some recession in business—in fact, it is already here—but they believe this recession will be short-lived.

Says Charles G. Dawes, for example: The present decline in security prices "does portend a comparative minor recession in business which, however, should not last beyond a year at the longest." General Dawes, it will be recalled, made the prediction in 1933 that stocks would sell within a year at 50% to 100% above their then-prevailing levels.

Another well-known seer, a professor at the Wharton School of Finance, agrees with the general. He adds four reasons for expecting a quick end of the downturn:

First, industry is not laboring under heavy inventories as it was in 1929 when stocks of unsaleable goods rested heavily on manufacturers' shelves.

Second, replacement needs of the country have not been satisfied; some three or four billion dollars of new construction is still necessary to catch up with housing requirements alone.

Third, although strikes still are plentiful, the labor situation gives evidence of clearing.

Fourth, there has been no over-expansion in business or in the stock market; Americans still remember 1929.

Although it is hardly likely that business will sit back long, some readjustment in prices is naturally to be expected. Pork, lamb, and beef prices, for instance, have risen out of sight of the average consumer. And business can not thrive if the consumer can not afford to buy the products that business has to sell. While such adjustment is taking place, the physician will do well to follow the advice of Benjamin Franklin and keep a reasonable amount of his capital in cash.

☆ ☆ ☆

"What can you suggest for a bad case of market-shocked nerves," a doctor asked me just yesterday.

"A triple bromide," I told him.

I was thinking of United States Savings Bonds—"baby bonds"—

which are sold at all Post Offices. These bonds come in denominations of $25 and up.

To any buyer who puts $18.75 on the barrel-head, the government will give a $25 bond. This bond matures in five years from the date of purchase. The owner then may turn it in for $25 in cash. Thus, he receives a "profit" of $6.25 on his purchase.

Of course, it is not a profit in the sense that a rise in the value of a stock might be interpreted. What happens is simply this: The investor purchases a government obligation. The government adds the interest up semi-annually. And, at the end of five years, it returns principal plus interest—in other words, the $18.75 plus what it has earned.

In terms of interest yield, the return—approximately 3%—is not large. But it's more than most savings banks pay. And behind it stands the credit of the government.

☆ ☆ ☆

Ever think of forming your own ten-year plan?

Frequently in the course of these articles, I have referred to investment trusts. There's good reason. Despite the losses which have been suffered by some investment trusts, and ignoring certain abuses in practice which the Securities and Exchange Commission is energetically fighting, the underlying theory of investment trust operation is sound.

Diversification is the keystone: "Don't put all your eggs in one basket."

I took time recently to interview the manager of investments for one of the leading trusts in the country. What he had to say—speaking for an organization with millions to invest—can profitably be absorbed by the physician who has only a few dollars to invest.

Let's take a look at his theory and apply it to everyday requirements:

This particular trust operates according to a ten-year plan. It invests only for that span. No stock is bought with the thought that a profit will be made on it in three or four months.

The trust officers select, say, ten leading American industries and allocate a certain amount of money for investment in each: chemical, department store, automobile, public utility, electrical manufacturing, railroad, aviation, etc.

Naturally, they buy the shares of leading companies in each field. The actual record shows that companies chosen for investment by this trust have been in profitable operation for a half century, during which time dividends have been paid to all owners of common shares.

Every three months—whether the market happens to be high or low—more shares are purchased.

In other words, the trust "averages up" and "averages down." It does not try to catch the day-to-day market moves.

Now how does its policy work? The answer is contained in the following figures: Over a ten-year period, from 1927 to 1936, inclusive, the trust's original investment has more than doubled—despite the debacle of 1929!

Any physician, no matter what his savings amount to, can take a leaf from this book of practical experience. He may buy, for example, one share or 100 shares of a steel stock this month; one share or 100 shares of a chemical stock two or three months from now; and keep on building until he has a diversified market interest.

When he operates on such a basis, he pays less attention to sudden market moves. A collapse in the market does not mean a rout. It simply means a new opportunity to increase stock holdings at a bargain level.

It is in this way that most American fortunes had their humble beginnings. To quote one of the fortune-builders of the last century: "I never tried to buy at the bottom or to sell at the top. I just bought and held on."

Working in favor of that type of investor is Old Man Interest. Dividends are paid on the investor's shares. These sums—if he is the frugal individual a fortune-builder must be—are immediately ploughed back into savings. They may be deposited in the bank until enough have accumulated to purchase more shares. Or, if the dividend is big enough, a few dollars may be added to the sum to buy more shares.

It is this process—the gradual building up of savings, plus the beneficial compounding of interest, plus re-investment of dividends—that makes your principal increase with amazing speed.

To use the words of one capitalist, lately deceased, "The hardest work was saving the first $1,000!"

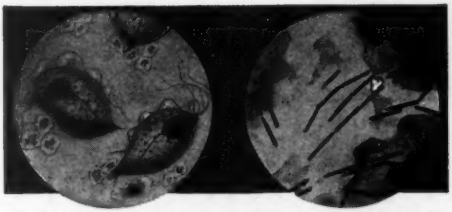
PLEASING PARENTS

WHEN A PATIENT happens to bring her child along with her to the office, I always get the youngster's name and file it on the parent's card. This makes for more personal contact. If the patient should not call again for a year or two, I can still ask, "And how is little Audrey?"—KURT BERLINER, M.D., New York, N. Y.

An Effective treatment for LEUKORRHEA

Many recent clinical and experimental observations have demonstrated that vaginal leukorrhea may be corrected by adhering to two important principles:

1. **Destruction of the pathogenic organisms**
2. **Rehabilitation of the glycogen depleted mucosa**



Fresh smear showing motile Trichomonas Vaginalis.

A pure culture of Doderlein bacilli following treatment with Floraquin tablets.

With the use of Floraquin tablets, destruction of the pathogenic organisms occurs, a normal glycogen-bearing epithelium develops, resulting in an acidity in which pathogenic organisms cannot exist, and favoring the growth of the normal symbiotic Doderlein bacillus.

Each Floraquin tablet contains 1½ grs. of Diodoquin (5-7-diiodo-8-hydroxyquinoline) together with specially prepared anhydrous dextrose and lactose, adjusted by acidulation with boric acid to a hydrogen ion concentration which maintains a normal pH of 4.0 when mixed with the vaginal secretion.

G. D. Searle & Co.

ETHICAL PHARMACEUTICALS SINCE 1888

NEW YORK KANSAS CITY CHICAGO SPOKANE LOS ANGELES

**This formula is available on prescription for $1.50 for 8 days' treatment*

HEPTOGENE FORMULA

EACH TABLET REPRESENTS APPROXIMATELY—

Liver Extract (Wilson) 2 2-5 grains (3100 mgms of fresh liver)
which acts as an appetite stimulant especially desirable when the anemia patient has a pronounced anorexia.

Iron Albuminate . . . . . **1 2-3 grains**
made with fresh egg albumin which is remarkably free from iron astringency.

Copper Biobasic . . . . . **1-100 grains**
the ratio of copper to iron is exact which guarantees the patient effective iron utilization without any excess to cause irritation.

Calcium Gluconate . . . . . **1 1-5 grains**
which is of special importance in pregnancy anemia usually concomitant with calcemia.

Vitamins—B (2 Sherman units)
G (10 Sherman units)

Commented on favorably in N. Y. State Journal of Medicine, July 15, 1937; N. Y. State Journal of Medicine, Aug. 15, 1937; Journal of the American Medical Association, Sept. 11, 1937.

Doctor, have you a case like this?

WE recently received an unusual letter from a New York physician describing the predicament of a W. P. A. worker afflicted with a serious anemia, concomitant with a subclinical scurvy. The doctor, who has long been a user of Heptogene*, asked if we would supply our product for treatment in this interesting and deserving case which he is taking care of free of charge.

Gladly, we provided an ample clinical supply and now welcome the opportunity presented by this and other letters to make clear our views on sampling.

We cannot afford broadcast sampling of our liver and iron hematic because of the high cost of these ingredients. Yet, if we are to continue to grow, our product must be brought to interested physicians for clinical test.

We know of no better way to accomplish this—to secure interested and prolonged testing in difficult cases than to seek out those doctors who have unusual and deserving cases, and to keep them supplied with Heptogene to the full extent of their requirement advantaging them whenever necessary with the full resources of our laboratory and our clinical files.

Doctor, if you have a case like this please write Biobasic Products, Inc.

BIOBASIC PRODUCTS, INC.

Rockefeller Center, New York City

IN SINUSITIS AND HEAD COLDS

When you prescribe a liquid vasoconstrictor, consider three points:

1 PROLONGED EFFECTIVENESS

'Benzedrine Solution' produces a shrinkage which lasts 18 per cent longer than that produced by ephedrine.

2 MINIMUM SECONDARY REACTIONS

On continued use 'Benzedrine Solution' produces practically no secondary vasomotor relaxation.

3 REAL ECONOMY

'Benzedrine Solution' is one of the least expensive liquid vasoconstrictors.

BENZEDRINE SOLUTION

Benzyl methyl carbinamine, S.K.F., 1 per cent in liquid petrolatum with ½ of 1 per cent oil of lavender. 'Benzedrine' is the registered trade mark for Smith, Kline & French Laboratories' brand of the substance whose descriptive name is benzyl methyl carbinamine.

SMITH, KLINE & FRENCH LABORATORIES

Philadelphia, Pa. Established 1841

☆ THE NEWSVANE ☆

PANELS WITHER THE THISTLE

Braw Scotsmen are as susceptible as their phlegmatic English cousins to malingering under a compulsory health insurance system providing cash benefits during disability. This is revealed in the latest report of the Department of Health for Scotland, covering incapacitating sickness among the insured population.

"The increase in chronic incapacity," says the report, "exceeds anything hitherto recorded." The average period of incapacity per insured person during the fiscal year 1935-36 was 11.45 days. That represents an increase of 5.3% over 1934-35. It exceeds the five-year average for 1930-35 by 14.7%.

While the Scottish rate was increasing steadily, the incidence of disability in the United States dropped from 112.4 cases per 1000 in 1929 to 78.1 in 1934.

BITTER CHARITY

"Is this another racket?" asks a letter written "by a mother" to the New York *World Telegram*. She leads up to her question as follows:

"Recently, I took my little girl to the clinic of an ear and eye hospital. It was found that she needed glasses. I was asked from $8.50 to $12 for glasses. I pleaded for the prescription, saying that I could have it filled by a licensed optometrist for $5 or $6. . . But I was refused.

"Is this another racket? If it is, it is a cruel and merciless one practiced on the needy in the name of charity."

THE COST: MEMBERSHIP

Economic reverses have dampened some physicians' ardor for medical ethics. Realizing this, a number of county societies are seeking means to restore it.

Under a proposed amendment to the Venango County (Pa.) Medical Society's by-laws, for example, no member may cooperate with a lay organization in a scheme requiring the services of physicians. That is, unless the society has approved the project. Offenders would automatically lose their membership.

A similar ruling has been adopted by the Hillsborough County (Fla.) Medical Society. By a vote of 96 to two, with only seven members absent, its constitution has been amended to bar from membership any physician engaging in unethical contract practice.

MEDICAL EXEMPTIONS

At least one newspaper with a sizable circulation has placed itself squarely behind the Health Guild of America, Inc.—an organization seeking a federal law to

permit sums spent on medical and dental care to be deducted from taxable income. Declared the Syracuse (N.Y.) *Post Standard* a short while ago: "Medical expenses are the greatest cause of financial trouble in this country. They are high, sudden, unexpected; and they upset budgets that have been balanced carefully otherwise. It is only just and fair that money spent for these purposes should not be taxed. . . The demand for such exemptions should be carried to Washington."

Already a bill seeking these exemptions awaits Congress' pleasure. Reposing now on the table of the Senate's finance committee, it would, if legislated, permit deductions for medical and dental services up to $250 per year (see October issue, page 142).

ONE-FEE-FOR-ALL FIGHT

For almost four hours the question was labored: Should upstate doctors get fees for compensation work as high as those paid to their colleagues in the New York metropolitan area? The discussion took place recently in a musty room at the State Office Building, Albany.

On one side were representatives of the New York State Medical Society; on the other, emissaries of various compensation insurance carriers and buyers. In between was State Industrial Commissioner Elmer F. Andrews.

Following is an outline of the meeting's cause, progress, and culmination:

In 1936 a minimum fee schedule was established for compensation work in the metropolitan district. Physicians from smaller population centers upstate requested that the same schedule apply there. But employers and insurance carriers demurred. "There must be a *downward* revision of the schedule in your case," they declared.

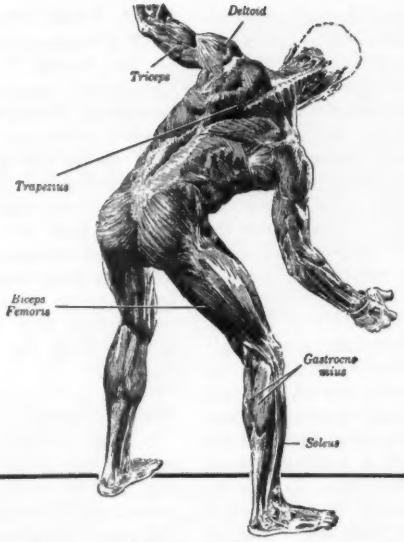
For over a year and a half attempts have been made to reconcile these differences. Even at the four-hour session a few weeks ago little progress was made.

Commissioner Andrews started things off by proposing a schedule sponsored by the Industrial Council of New York. It calls for application of the metropolitan schedule in cities of 75,000 or more, a downward differential of 10% in communities of from 35,000 to 75,000, and a 15% reduction in all other sections.

Drs. D. J. Kaliski and Frederic E. Elliott, officials of the state society, opposed such a compromise. They stood pat for adoption of the metropolitan schedule throughout the state.

Then a spokesman for the employer group took the floor. "A 25% reduction in compensation fees for all communities outside the metropolitan district would be none too much," he claimed.

The physicians refused to capit-



To Relieve Muscular Congestion Suggest

ABSORBINE Jr.

WHEN PATIENTS COMPLAIN of sore, aching muscles, suggest a rubdown with Absorbine Jr. at home.

An Absorbine Jr. rub relieves congestion and muscular fatigue . . . for it causes the blood to circulate more freely . . . and collected toxic waste products are washed away. As congestion is relieved, painful soreness and stiffness begin to disappear.

Recommend Absorbine Jr., too, for home treatment of bruises, bumps, sprains, wrenches.

Write for a complimentary professional-size bottle of Absorbine Jr. See for yourself how promptly Absorbine Jr. acts!

W. F. YOUNG, INC., 399 Lyman St., Springfield, Mass.

ulate. An upstate doctor's expenses are as high and his services are as valuable as those of his colleagues in the city, they declared.

The probable result of the hearing, it is said, will be the appointment of a special committee to continue to worry the problem in an attempt to shake out a solution. Its members will be drawn from the state medical society and from the insurance companies.

MORE ON ALCOHOLISM

The growing conviction that chronic alcoholism should and can be treated medically, not socially (see September issue, page 72), was substantiated recently when the Mc Lean Hospital, a leading private psychiatric institution in Massachusetts, released its report on a study of the question, "Can a chronic alcoholic be cured?"

A ten-year observation period, the hospital declares, has revealed that, fundamentally, alcoholism must be considered as a disease. It adds that patients in their middle thirties who have been drinking heavily for as many as seven years may well be cured. After forty, the seven-year toper is said to have a slim, but neverthless worthwhile chance.

B.M.A. HEAD REGRETS

Sir E. Farquhar Buzzard, president of the British Medical Association, flayed compulsory health insurance at a recent gathering of English physicians. Said he:

"The chief flaw in a badly organized service, such as that which has evolved in this country. . . , is lack of time. Both the general practitioner and the consultant, in order to earn a living wage, are frequently obliged to undertake far more work than they can deal with efficiently in the hours at their disposal."

PRESS CLOSER

Several pickets were knocked recently out of the fence separating A.M.A. officialdom and the newspapers. Trustees of the A.M.A. and representatives of the National Association of Science Writers met in Chicago to discuss public relations problems affecting the medical profession and the press.

Summarized, here's what the newspapermen want: establishment of a national medical news clearing house; a more generous supply of medical news pictures; direct reporter-doctor contacts; "medical police cards" for qualified newsmen; no censoring of medical news;

more awareness by physicians of the public welfare phase of medical news and less apprehension of its effect on individual doctors; organization along professional lines of the dailies' news and editorial departments.

As yet, the issues raised have not gotten beyond the conference stage. But Waldemar Kaempffert, science editor of the New York *Times* and president of the writers' association, has urged the A.M.A. to appoint a committee for further discussion of the press-medicine problem.

This development is in line with a statement made by MEDICAL ECONOMICS on page 23 of its last issue: "A permanent A.M.A. publicity bureau would wipe out this gulf between the physician and the press. Its trained men, selected by the profession, would interpret medical achievements accurately, as the physician has a right to expect, and colorfully, as the public demands. It would be welcomed by doctors and newspapermen alike."

DIABETES SOCIETIES URGED

Among doctors the diabetic death rate is 10 per thousand. Among laymen it is 45 per thousand. Dr. Elliott P. Joslin, clinical professor of medicine at Harvard wove those statistics into a recent plea for organized control of diabetics.

Addressing the annual convention of the Michigan State Medical Society, Dr Joslin called for physician-managed associations to keep laymen as fully informed as doctors about the strict regimen essential to a diabetic's life. Such associations, he pointed out, would function along the lines of those for the control of tuberculosis.

The problem of financing diabetic associations would not be serious, he added, because, "So many among the well-to-do have diabetes."

LICENSURE TURMOIL

Licensing of foreigners continues to be a bone of contention.

In September, 1936 the New York State Board of Regents nullified a law which had permitted an inordinate number of foreigners to practice in the state without having to pass state medical board examinations. (During the five years prior to September, 1936, 843 foreign physicians were licensed in New York as against a total of 478 in 36 other states.)

The Non-Sectarian Anti-Nazi League decided to question in court the board of regents' right to clamp down on foreigners in his way. Samuel Untermyer, president of the league and nationally prominent lawyer, went to the state supreme court with the case of four German physicians whom the regents had refused to license with-

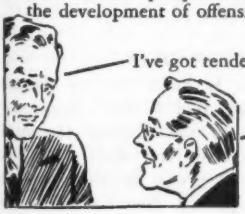
I'M GLAD *MY* DOCTOR TOLD *ME* THIS ABOUT "B.O."!

Could *I* have "B. O."? I can't close sales . . . I can't hold friends.

Anyone can be guilty of "B. O." Even inactive individuals perspire a quart or more each 24 hours. *What* we perspire contains organic waste materials. In the presence of oxygen and bacteria this excreted matter tends to break down into odoriferous compounds . . . but, no one needs to have "B. O."

You mean there is something safely effective that I can use?

Exactly. Something easy, and *refreshing*, too! A daily Lifebuoy bath stops "B. O." by removing stale perspiration. Lifebuoy contains an exclusive purifying ingredient—refined cresols—*not* in any other toilet or bath soap. This ingredient aids in preventing the deterioration of perspiration, hence, it retards the development of offensive body odors.



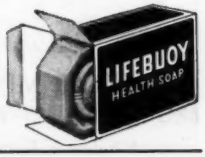
I've got tender skin, you know . . .

You'll *doubly* appreciate Lifebuoy. Scientific tests have proved its special ingredient makes it milder . . . over 20% milder than many leading "baby" and "beauty soaps."

Professional samples on request

Your briefest request on a letterhead will bring you, with our compliments, samples of Lifebuoy, so you can test its unique qualities for yourself.

LEVER BROTHERS CO., Dept. 4912, Cambridge, Mass.



out examination. The purpose was to secure a court order reversing the regents. But before the court reached a decision, the regents reversed themselves, granting the mooted licenses recently.

Still up in the air is the question raised by Mr. Untermyer: "Has the state board of regents the power to nullify the licensure statute under which it acts?"

CHILDREN NOT TO BE SEEN

The increasing tendency to show babies along with prize cattle, pumpkins, and preserves at county fairs has been roundly berated by the Gregg County (Texas) Medical Society. At a special meeting the society recently put its collective foot down on a baby show proposed for the coming local county fair. Spread upon the minutes of that meeting is this argument against group exhibiting of infants:

Adequate examinations of the displayed infants cannot be made during the noisy hustle of a fair. Such check-ups, being hurried and incomplete, reveal only gross defects. Since less obvious defects escape detection, parents attain a false sense of securiy.

DESIGN FOR GIVING

Business is more apt to donate when appealed to on a business-like basis, the United Hospital Campaign of New York City believes. The group has developed a new approach for contributions from firms and corporations. The latter are asked to give on the basis of an "employee unit plan."

Under this plan, with few exceptions, there is no direct solicitation of employees. Instead, the management of a business is asked

to give at the rate of $4 per employee on the payroll of its New York City facilities.

The fund-raising committee, in explaining its new design for giving, hastens to add that it is not meant to limit those who have contributed more than $4 per employee in the past.

Executives are excluded from the employee-unit plan. As heretofore, they are approached for personal donations proportioned to their pocketbooks.

A.M.A. BROADCASTS ON TRIAL

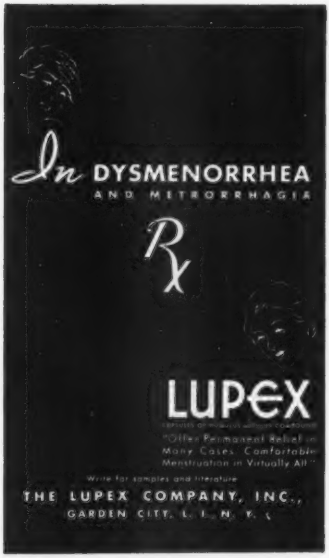
The A.M.A. is wondering if anyone listens to its radio programs and why. So WPA workers in Cleveland, Ohio will prod thousands of local doorbells in an effort to find out. They will ask: "Does the family listen to the American Medical Association's broadcasts? If so, how interesting are they?"

Those who disclaim familiarity with the programs will be urged to tune them in for a while. They'll be called on again and asked "Are you listening? Any comment?"

TO BOOM SYPHILIS TESTS

Convinced that in Wassermanns, as in fashion, the masses follow the classes, 35 socially prominent women of Montclair, N. J., volunteered last month to be tested for syphilis. "We hope by example," said an official of the Montclair League of Women Voters, "to remove some of the stigma attached to taking the Wassermann test, and to encourage the treatment of syphilis as a disease, not a disgrace."

Admittedly, the best-circle matrons' action is not entirely altru-



istic. They realize that it is one way to put the quietus on domestics who resent taking Wassermanns unless their madams and masters do so too.

Other example-setters are the directors of Chicago's city-wide campaign against syphilis. At a recent luncheon meeting they submitted to the Kahn test which they are asking a million citizens to take. Dr. Reuben Kahn, developer of the test, officiated in a white surgical gown and rubber gloves.

Dr. Herman N. Bundesen, president of the Chicago Board of Health, and other notables gave blood samples.

Dr. Louis D. Smith, chairman of the Chicago Medical Society's committee on venereal disease, told newspapermen at the luncheon that a majority of the city's general practitioners would aid the campaign by taking blood samples gratis. Tickets for free examinations by cooperating doctors are being distributed to employees throughout the city. After the tests have shown who needs treatment, facilities established by city, state, and federal bureaus will open to the needy afflicted.

TROPHY BUILDS PRACTICE

Single in purpose, but twofold in result is a health trophy put up recently by the Medical Association of Georgia. Its purpose and one of its results is the promotion of preventive medicine by units of the state's Parent-Teacher Association. The other result is increased practice for local doctors.

The trophy will be awarded annually by the Georgia Congress of Parents and Teachers to that

[*Turn the page*]

P.T.A. district having the best record in preventive activities. Physical examinations of parents and teachers, in addition to immunization of schoolchildren, count heavily in the scoring.

BETTER REBUTTERS

Too few doctors take the platform to defend private practice against the attacks made on it, believes Dr. Harry C. Guess, chairman of the education committee of the Erie County (N. Y.) Medical Society. For that reason his association launched a course in public speaking three months ago, which terminated this month.

A score or more of physicians took the course. On eleven consecutive Thursdays they polished their diction and gained platform presence under the expert tutelage of an English professor from the nearby University of Buffalo. Now they are described as "highly articulate, rid of natural reticence, and capable of rebutting medicine's destructive critics right off the rostrum."

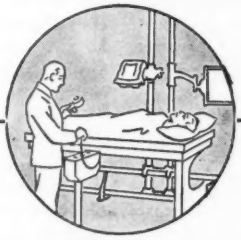
UNCLE SAM AND CANNABIS

Alarmed at the increasing marihuana habit, the federal government has decided to curb it. Under a law effective October 1, cannabis is as government-controlled as drugs under the Harrison Narcotics Act.

Says the law: "With the exception of federal, state, and municipal officials, every person who imports, manufactures, dispenses, or prescribes cannabis . . . must register annually in the office of of the Collector of Internal Revenue . . . and pay a prescribed tax."

For physicians the tax is $1 a year. [*Turn the page*]

How Much do your Intensifying Screens Help YOUR X-RAY EQUIPMENT?



THE PURPOSE of intensifying screens is to improve such factors as contrast and speed in making X-ray negatives. However, in order to use intensifying screens to fullest advantage, it is necessary to carefully select them for quality and type.

Because the X-ray machines and tubes of today are extremely sensitive and highly refined pieces of equipment, they must be used in conjunction with intensifying screens which are just as highly refined . . . otherwise this expensive equipment will not function to best advantage.

You can insure best results from your X-ray equipment by standardizing on Patterson Intensifying Screens. For Patterson Screens are the accepted standard for high quality throughout the world . . . and you can select *exactly* the type or types of screens you should have from the comprehensive Patterson Line. Your dealer will gladly furnish complete information.

NEW AND HELPFUL INFORMATION
The following new Patterson Leaflets are now available: (1) Cassette Contact; (2) Care of Intensifying Screens; (3) Patterson Mounting Paste and Method of Mounting Intensifying Screens. Send for any in which you are interested.

THE PATTERSON SCREEN COMPANY
TOWANDA, PA.

Patterson
X-RAY
Intensifying **Screens** Fluoroscopic

SCREEN SPECIALISTS FOR MORE THAN TWENTY YEARS

Forms similar to those used when buying opium, cocaine, etc., must be used for cannabis. Orders must be made in triplicate. One copy is for the physician, one for the seller, and one for the collector. Prescriptions must be kept subject to inspection for two years. Upon request from the authorities, any registered handler of cannabis must account for any amount of the drug received during the three preceding months.

The maximum penalties for violations are a $2,000 fine, five years in prison, or both.

Applications for registration are procurable from district collectors of internal revenue. They also have copies of the new marihuana regulations.

10c WORTH OF GOD-HELP-US

The pre-Christmas good-will of many Canadian physicians is being sorely tried by rumors that hospital authorities in one of the provinces intend to retrieve a resolution thrown out at a regional meeting some time ago. The "whereases" amount to this: Municipal hospitals are built, equipped, and staffed at the laity's expense; doctor's contribute nothing toward their upkeep although they use hospital facilities freely to further their practices. Therefore, the resolve: Physicians must pay 10c per patient day for all private and charity patients hospitalized under their care.

QUACKS, SCANDINAVIAN STYLE

Jep Nissen, known as "the king of Danish quacks," is hungrily eyeing U. S. territory. In fact, Nissen has already sold what he is pleased to call licenses in three states—Iowa, Minnesota, and Wisconsin. That makes it all right for enterprising distributors in those states to unload what many of Nissen's Scandinavian patients call his miracle medicine and what Danish medical authorities call nostrums.

The law has been unable to pin more than a few fines on Nissen. None of his thousands of spellbound clients is willing to testify against him.

Another notorious Danish quack, Laust Nielsen, was convicted recently of having violated the Danish health act. He was fined 250 Kroner (about $55). The judge added that the amount would be doubled next time. No sooner had the verdict been handed down than one of the courtroom audience came forward to say that on behalf of some 1,600

CANNED FOODS IN THE CONTROL OF LATENT AVITAMINOSIS A

• Cases of severe vitamin A deficiency are extremely rare in this country. Recent medical research, however, has shown that latent avitaminosis A occurs more frequently than hitherto might have been suspected (1).

Fortunately, latent avitaminosis is capable of early clinical detection. One of the first effects of prolonged suboptimal vitamin A intake is a lowered dark adaptation of the eye. Any deviation from normal in this respect can be readily determined by the photometer. A second direct result of continued mild avitaminosis A is the cornification of epithelial cells in certain tissues. The presence of such cornified cells in scrapings from the bulbar conjunctiva is indicative of avitaminosis A.

Using such methods, investigation has been made to determine the frequency of latent avitaminosis A in representative groups of American adults and children. The results of these researches are of interest to everyone concerned with human nutrition.

First, it has been shown that the incidence of latent avitaminosis A in America is surprisingly high. For example, in one instance (1d) more than one-third of the adult group under investigation displayed evidences of mild vitamin A deficiency; again, from one-fourth to three-fourths of the members of representative groups of children displayed similar manifestations (1b).

Second, it has been found that, in general, subjects exhibiting symptoms of mild avitaminosis A had been maintained on diets which may be considered suboptimal with respect to vitamin A. Last, but by no means least, it appears that these avitaminoses may be corrected and controlled by specific vitamin A therapy; by readjustment of the diet to provide a more liberal supply of vitamin A; or by a combination of these two procedures.

When readjustment of the diet to increase the vitamin A intake is being considered, attention might well be directed to commercially canned foods. Biochemical research has established that the canned varieties of foods notable for their vitamin A content are valuable dietary sources of the vitamin (2).

Available at all seasons on practically every American market, commercially canned foods will prove economical and reliable in the formulation of dietary regimes calculated to control latent avitaminosis A.

AMERICAN CAN COMPANY
230 Park Avenue, New York City

1a. 1934. J. Amer. Med. Assn. 102, 892.
b. 1936. Ibid. 106, 996.
c. 1937. Ibid. 108, 7 and 15
d. 1937. Ibid. 109, 756.

2. 1931. J. Nutrition 4, 267
1932. Ind. Eng. Chem. 24, 650.
1933. J. Amer. Diet. Assn. 9, 295.
1935. Amer. J. Public Health 25, 1340.

This is the thirty-first in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. What phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. Address a post card to the American Can Company, New York, N. Y.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

of Nielsen's patients, he wanted to pay the fine. The quack's Samaritan added that he and other devotees of this "great natural doctor" would undertake to pay all future fines which might be imposed upon him.

PIG BANKS HELP LEPERS

How 100,000 iron pig banks provided the American Mission to Lepers with over $1,000,000 was explained recently.

Twenty-two years ago a young Kansan raised a pig, sold it, and sent the resulting $25 to the mission. The deal was described at a prayer meeting of employees at the Scranton (Pa.) *Sunday School Times.* It inspired one of the staff to buy a pig bank which she and others on the paper could feed with dimes. When the pig was full, its contents were sent to the mission.

Thanks to a little publicity, pig banks are now the source of more than half the society's income.

Rx: ETHICS

Here's how a recent bulletin of the Indianapolis Association of Retail Druggists decries counter-prescribing:

"A good percentage of those suffering from syphilis received their first treatment at the hands of the pharmacist. Let us call your attention to the fact that there is still a code of ethics so far as pharmacy is concerned. In prescribing for cases of this kind or in suggesting treatment you are shooting in the dark with no ideas as to the ultimate results. An accurate diagnosis entails laboratory tests which we as pharmacists are not in a position to carry out.

"By suggesting or prescribing for this form of ailment you may be a material contributing factor in spreading syphilis. If the patient is in a position to pay, send him to your closest physician. If he is not in a position to pay, he will be taken care of at the city hospital."

BABY DEAR TO THREE

"The injuries she has sustained will prevent this woman from having a baby," testified a physician during an auto-accident suit in Illinois some months ago. The woman was suing for $5,000. She won. The defendant appealed. Recently, while the appeal was pending, the plaintiff had a baby. But the defendant's high hopes that the birth would save him $5,000 were soon dashed. The appellate court ruled that the infant was new evidence which it could not consider.

OUTLAW HOSPITALIZATION

A number of illegal hospital insurance companies have settled in Florida. The state insurance department reports that it has run about forty such outlaws out of the state. However, others continue to spring up.

According to latest reports avail-

able, Florida has only two companies authorized to sell hospital insurance. One of these, the first to receive a permit from the state insurance department, has given evidence of strictly honorable intentions. Voluntarily, it has submitted its policy for approval by the Florida Medical Association. In addition, it promises to avoid infringing on the profession's territory and ethics.

DENTISTS TEST ADS BAN

For the third time the constitutionality of a law prohibiting dentists from advertising is being tested in New Jersey. Twice the state board of dental examiners has revoked a dentist's license because he advertised. This was done to test the statute. Each time the state supreme court set aside the board's action

on mere technical grounds. It did not rule upon the legality of the act.

The law has been called unconstitutional on two scores: "(1) it erects a wall of silence behind which monopoly and high prices may flourish, and (2) it infringes newspapers' constitutional rights by limiting their freedom to accept advertising."

Ethical dentists have called attention to the fact that the U. S. Supreme Court has upheld a similar law in Oregon. Their opponents point out that the Oregon law is "utterly different." It prohibits only certain types of advertising; the New Jersey statute bans all.

FOR CONQUERING CANCER

Another big gun has been added to the research artillery now barraging cancer. The Chicago Tumor In-

stitute will open next March. Although its activities will be national in scope, funds to support it have been contributed entirely by Chicagoans. The new institute is the sixth in the United States to be devoted exclusively to cancer study.

To Henry R. Luce, publisher of *Time*, *Life*, and *Fortune*, and the man behind the *March of Time* motion picture series, the American Society for the Control of Cancer has awarded the Clement Cleveland medal. The medal is given annually in recognition of "outstanding work in the campaign to control cancer." Mr. Luce was thus honored for his *March of Time* chapter, "Conquering Cancer," released last January.

POLLEN TRAP

An electrostatic air cleaner now being marketed is claimed to remove all pollen and nearly all other air-borne particles from a room. The claim has been substantiated through tests made in smoke-polluted Pittsburgh, Pa. by Drs. Leo H. Criep and M. A. Green. They report: "A study of 61 patients seems to indicate that the electrostatic cleaner has a place in the treatment of certain refractory cases of hay fever, pollen asthma, and bronchial asthma."

Electrostatic air cleaners cost around $250, weigh about 150 pounds, and are the size of a large console radio.

They are portable and consume about as much current as a 60-watt bulb.

HOW'S YOUR HEART?

The average physician's chance of dying from heart disease is almost twice that of the average layman. That arresting statistic is the highlight of a study made by Dr. A. Morris Ginsberg, of Kansas City, Mo. Heart disease, he says, claims 40% of all physicians, 23.85% of the general population.

On the basis of authentic statistics Dr. Ginsberg has built these other interesting facts:

Both New Year's Day and the ides of March are as sinister to doctors as the ides was to Caesar. For five years more doctors have died in March and January than during any other month.

At about age 27, the average doctor has a life expectancy of 64.1 years; the average white male, 67.51 years.

From 1931 to 1935 the percentage of heart deaths among physicians has increased 4.45%.

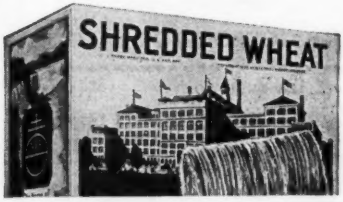
In 1935 myocarditis and endo-

A PATIENT ALWAYS LOOKS FOR THIS:

A balanced, digestible diet containing those necessary food elements that will result in more energy and endurance.

BUT HE DOESN'T ALWAYS KNOW THIS:

Whole wheat supplies an unexcelled balance of carbohydrates, mineral salts, proteins and vitamins. And Shredded Wheat *is 100% whole wheat* in its most digestible form. An excellent diet recommendation.



LOOK FOR THE SEAL OF PERFECT BAKING

SHREDDED WHEAT IS A PRODUCT OF NATIONAL BISCUIT COMPANY

MORE THAN A BILLION SHREDDED WHEAT BISCUITS SOLD EVERY YEAR

carditis claimed 355 physicians; coronary thrombosis, 220; angina pectoris, 146; pericarditis, 2; and other cardiac ailments, 622.

Dr. Ginsberg points accusingly at the fact that so many doctors' death certificates fail to identify the heart disease involved. Surely in the profession, he declares, the cause of death should be described specifically. "Why not arrange for your own postmortem?" he asks, in effect, "Wouldn't that stimulate postmortems among laymen?"

HANDLING FOOD HANDLERS

A new Wyoming statute requires food handlers to be physically examined. Printed forms issued to physicians make it clear that the health check-ups must be complete. Required are nose, throat, chest, and skin examinations; the Kahn test (every six months); and, when indicated, microscopics for Neisserian infection, diphtheria, hemolytic streptococcus, and tuberculosis. Also, a report must be made as to whether or not an examinee has been immunized for diphtheria, scarlet fever, typhoid, and smallpox.

The Wyoming Medical Society has suggested that fees for such examinations may well be established at $5 to $6 if a blood test is made; $2 to $3, otherwise.

CANCER GROWS FOR MOVIE

The world première of a motion picture of cancer progressing in an animal's body took place at the recent meeting of the National Academy of Sciences in Rochester, N. Y. Drs. A. Gordon Ide and Stafford L. Warren, of the University of Rochester, had planted

a cancer growth in the tissue at the thin part of a rabbit's ear. Then they had focused a microscope camera on it. The result showed cancer cells moving into the blood stream through injured blood-vessel walls.

STARCH FOR OSTEOPATHS

Bowing to the increasing number of basic science statutes, the Associated Colleges of Osteopathy have decided to put a little starch into their entrance requirements. As a result, starting next year, a minimum of one year of approved college work will be a requisite for admittance to class A osteopathic colleges. From 1940 on, two years of college education will be required.

In announcing this, the American Osteopathic Association questioned the value of basic science acts thus:

"The validity of a system which gives state boards of examiners dictatorial control over the type of education of physicians may have been expedient. But as a principle of education it leaves a great deal to be desired. Politically-appointed examining board members . . . can by no means be expected to know as much of the

administration of higher education as do properly trained faculties and college administration personnel."

AT THE A.C.S. CONGRESS

At the recent annual meeting of the American College of Surgeons in Chicago—

C. Rufus Rorem, director of the American Hospital Association's committee on hospital service, forecast that ten million Americans will have hospitalization insurance by 1942.

It was revealed that the number of approved hospitals in the United States has increased by about 1% over last year.

Dr. Frederic A. Besley, of Waukegan, Illinois, assumed the presidency of the college, while Dr. Howard C. Naffziger, of San Francisco, became president-elect.

Dr. Eugene H. Pool, in his address as retiring president, identified what many consider the college's major new objective:

The period in the development of a surgeon between the acquisition of his medical degree and his qualification as a surgeon, explained Dr. Pool, may be termed the graduate stage, as distinguished from the undergraduate and the postgraduate. The college proposes to initiate training for these "graduates" in numerous properly equipped hospitals throughout the country.

"The required opportunities and facilities for such training," Dr. Pool added, "exist only in a limited number of teaching hospitals. . . It was, therefore, recommended that non-teaching hospitals with proper personnel, plants, and organization be encouraged to undertake graduate training for surgery."

"HAM" LEWIS ROASTED

The Illinois State Medical Society is trying to offset the potential danger to the profession created by Senator J. Hamilton Lewis' now notorious Senate Joint Resolution 188. The resolution would federalize the profession, making every physician a civil officer subject to prosecution and penalization in the federal courts.

To medical associations throughout the country, the Illinois society has sent copies of two resolutions—namely, Senator Lewis' and one passed by the society. The society's describes S. J. 188 as "inimicable to the best

A properly proportioned ration—that is, a food mixture containing the food constituents, namely fat, carbohydrates and protein, in approximately the same proportions as those found in woman's milk,—can easily be achieved

by adding	*by adding*	*by adding*	
			
to water	to diluted fresh milk	to diluted evaporated milk	COMPARED WITH NORMAL HUMAN MILK
YOUR PRESCRIPTION	**YOUR PRESCRIPTION**	**YOUR PRESCRIPTION**	
B	B	B	
Lactogen . . 1 part	Fresh milk . . 1.5 oz.	Evaporated milk .75 oz.	
Water . . 7 parts	Water . . . . 1 oz.	Water . . . 1.75 oz.	
	Hylac . . 1 measure	Hylac . . 1 measure	
2½ oz. per lb. of baby's weight	Per lb. of baby's weight	Per lb. of baby's weight	
RESULT	**RESULT**	**RESULT**	
FAT 3.1%	. . . 3.0%	. . . 3.4%	. . . 3.5%
SUGAR . . . 6.7	. . . 6.1	. . . 6.4	. . . 6.5
PROTEIN . . 2.0	. . . 2.1	. . . 2.3	. . . 1.5
SALTS (Ash) . .4	4	5	2
CALORIES			
Per oz. . . . 20	. . . 20	. . . 21	. . . 20
Per lb. of baby's weight . . 50	. . . 50	. . . 53	. . . 50

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public interest, un-American, and unworkable," adding that it would result in "monumental expenses without yielding compensation benefits, would lead to political corruption, and ought to be defeated."

President Roosevelt and each Illinois senator and representative have also received copies.

Dr. John R. Neal, chairman of the Illinois State Medical Society legislative committee, told MEDICAL ECONOMICS last month that 35 medical associations, roused by the two resolutions, have agreed to cooperate in "crushing Mr. Lewis' atrocious measure."

M. D.'S ATTACK HOLC PLAN

Attacking vigorously along three fronts, the District (Washington, D. C.) Medical Society is taking drastic action against the Group Health Association, Inc., of the Home Owners' Loan Corporation. This project sets up a federal agency to provide medical care on a prepayment basis to some 2,000 HOLC employees. It may be extended to include nearly a million government employees in all parts of the U. S. (see October issue, page 90). At a special meeting last month the society discussed plans to (1) institute legal proceedings to prove the HOLC guilty of corporate medical practice; (2) establish the fact that it is selling insurance illegally; and (3) close Washington hospitals' doors to members of the plan.

The society has pointed out that it can forbid its members to practice in hospitals serving HOLC beneficiaries. Admittedly, such a step would be the most radical taken

against federal supervision of medicine.

Already, according to a report from Washington, two physicians employed by the HOLC have resigned from the society. Their resignation followed a warning that society members could not ethically work for the project.

MEDICINE'S HAT IN THE RING

A few weeks before Election Day, New York City physicians, interest and curiosity piqued, read the following among the New York *Times* personals:

"Young college men and women wanted—volunteer campaign workers for municipal election (independent candidate endorsed by city Fusion party). Apply Physicians & Allied Professions Non-Partisan League, Murray Hill Hotel, Park Ave. and 41st St., Suite 90."

That was one of the steps taken by the league in an effort to elect Dr. Charles N. Gelber, ear, nose and throat specialist, as city councilman of Manhattan. His candidacy marked the league's first venture into politics.

The Physicians & Allied Professions Non-Partisan League was born in 1933. Then a group of doctors banded together hastily to handle what they deemed an emergency—namely, a move to force Dr. William H. Park, city bacteriologist, into involuntary retirement because of his age. They were able to convince the city fathers that Dr. Park's capabilities were such that his seventy years should be discounted. Later the league succeeded in doing the same thing for Dr. Anna W. Williams, Dr. Park's assistant.

[*Turn the page*]

Gratified at their success, the founding group agreed to remain leagued for the city's health.

This year New York City's new proportional representation plan went into effect. So, the league decided to support its own independent candidate. Dr. Gelber was drafted. His platform called for the establishment of more clinics, the promotion of health examinations, and slum clearance. (One member campaigned for more comfort stations).

Due to the fact that a vote count under the proportional representation plan will take anywhere from two weeks to a month, it is not known at this writing how Dr. Gelber fared at the polls. However, the league has turned all possible electioneering stones. Under its direction, volunteer campaign workers from local medical and civic groups stumped zealously. Thousands of New York City physicians promised their support, as did many laymen, both party members and independents.

To MEDICAL ECONOMICS the league has explained that, thus far, its political activities have been local. But it hopes that similar groups will be formed elsewhere; that in the not-too-distant future such local units will form a national medical-political body.

COMPENSATION LAW REFORM

New Year's Day will mark the beginning of a better era for physicians affected by Pennsylvania's workmen's compensation law. A new law, resulting from three long years of trying by the state medical

The physician is the authority for the diagnosis

Mazon publicity does not encourage self diagnosis. Our advertisements are confined solely to the Medical Profession. Our fullest co-operation is at your disposal.

Professional endorsements and Authentic case studies are, we believe, the best methods of recording the merits of Mazon treatment.

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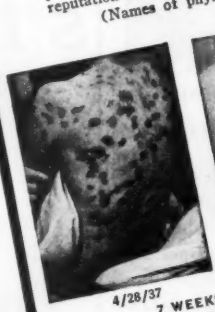
"I have been prescribing Mazon ungt. and soap wherever indicated, extensively for the past 10 or 12 years and after I have prescribed it, I have ceased to worry over the outcome of these cases. In practically each instance my results, have been all myself and patient could wish for.

from Bolivar, Mo.
"I prescribe it (Mazon) frequently and have never had it fail yet. My druggist carries a supply at all times and I assure you it has quite a reputation in this community."
(Names of physicians on request.)



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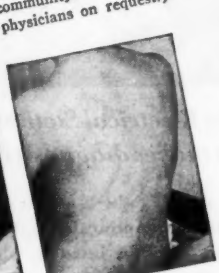

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society, embraces these features:

A ninety-day limit supplants one of thirty days during which medical care must be furnished by employer or insurance carrier. The state compensation board can extend this limit for deserving cases.

Artificial appliances, in addition to ordinary hospital and medical care, must be supplied.

A $200 fee limit replaces one of $100. This applies to the first ninety days. The fee limit will be increased according to any extension of the time during which an employer must pay for medical care of an employee.

Physicians treating compensation cases are given a definite standing at law. Now they can take legal steps against employers or insurance carriers refusing to pay fees for services rendered to workmen.

However, before instituting such action, a doctor must secure his patient's consent. The state society points out that patients will be importuned by insurance carriers to refuse. Therefore, it adds, the securing of a signed consent should be routine when commencing treatment of a compensation case. This would spike counter-claims that services rendered were not authorized.

REINS ON PNEUMONIA

In New York State the profession is making sure that ground gained against pneumonia will not only be kept, but increased. The state society has engaged in a concerted effort to decrease pneumonia mortality through education of the public and the profession and by more

widespread use of anti-pneumococcus serum. Needed fuel for the campaign was supplied this year by the passage of a bill granting $400,000 for "furthering . . . the control of pneumonia."

The society has undertaken a series of one-day institutes on the diagnosis and treatment of pneumonia. This has been done through cooperation with the bureau of pneumonia control of the New York State Department of Health and with a number of large medical school hospitals.

Special emphasis is being placed on serum therapy. General practitioners throughout the state will familiarize themselves with its exact technique. Institutes will be held in five centers—namely, Albany, Buffalo, New York City, Rochester, and Syracuse. Fifty physicians can be accommodated at each institute. There are no fees for attendance. Furthermore, the department of health will underwrite expenses for those attending, up to a maximum of $20 per man. Efforts are being made to maintain a proper ratio between the number of those admitted to the institutes and the size of their respective counties.

An extra fillip was added to the pneumonia-control drive when the department of health offered a prize of $100 for the best case-history series on the disease. The prize, put up early this year, was won recently by Dr. Walter J. Karwowski, of Johnson City.

FREE-CARE CLEARING HOUSE

The Indianapolis Medical Society in concert with other local organizations seeks data on how to establish a central bureau for the registration of indigents. It has solicited information from MEDICAL ECONOMICS and from several city health departments. Plans to organize such a bureau in Indianapolis got under way shortly after publication of MEDICAL ECONOMICS' editorial "Certification of Indigents" (see August issue, page 36).

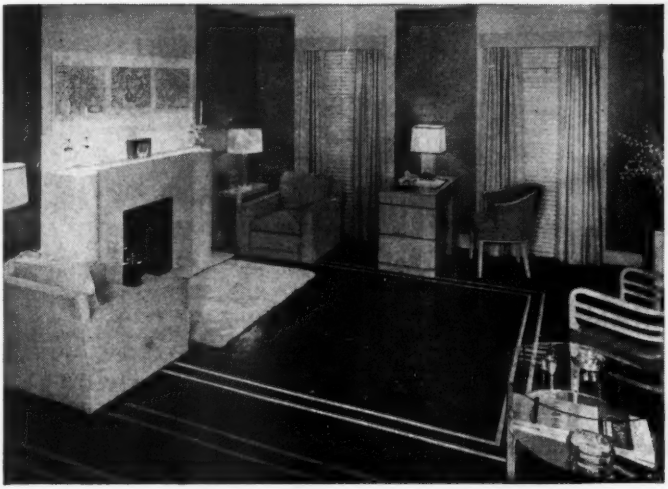
In brief, here's what a central registration bureau accomplishes:

1. Financial and credit investigation of all persons seeking free medical and hospital service.

2. Provision of prompt service for worthy applicants.

3. Elimination of undeserving applicants.

4. Classification of non-charity patients on part-pay and full-pay bases.



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ARTICLES

HURDLES FOR YOUNG DOCTORS, by Hugh Cabot. (*American Scholar*, Autumn, 1937)

TURN YOUR SICKNESS INTO AN ASSET, by Louis E. Bisch, M.D. A new philosophy of sickness. (*Reader's Digest*, November, 1937).

WOULD YOU LIKE UNCLE SAM TO BE YOUR FAMILY DOCTOR? Thirteen laymen answer the question. (*American Magazine*, November, 1937).

REPAIR VS. RELIEF IN WEST VIRGINIA, by J. D. Ratcliff. How one state has given medical aid to its indigents to fit them for work. (*Survey Graphic*, November, 1937).

A COMPULSORY TEST FOR SYPHILIS BEFORE MARRIAGE? A skilled investigator discusses the subject. (*Reader's Digest*, November, 1937).

JOURNEY'S END, by Don Daugherty. The final episode in a "chronicle of pain." (*Coronet*, November, 1937).

BOOKS

DOCTORS ON HORSEBACK, by James T. Flexner. Pioneers in American medicine. (Viking, $2.75)

THE DIARY OF A SURGEON IN THE YEAR 1751-1752, by John Kynveton, edited by Ernest Gray. A London doctor tells all. (Appleton-Century, $2.50)

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Soothe the inflamed mucous membrane and ease the distress in acute and chronic infections of the urinary tract. Minimize pain and assist recovery after urogenital procedures. Reduce the discomforts secondary to an enlarged prostate.

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Taurocol (bile salts, cascara, phenolphthalein, oleoresin capsicum, oil of peppermint) provides necessary pharmacodynamic influence in many forms of chronic gallbladder disease. Biliary drainage is enhanced, peristalsis stimulated, and gastric emptying is hastened. As a result, food intolerance disappears, abdominal discomfort is relieved, and constipation is overcome.

TAUROCOL COMPOUND (Plessner)

Taurocol Compound contains, in addition to the ingredients of Taurocol, pepsin and pancreatin. It aids in the gastric digestion of proteins, and in the digestion of proteins, fats, and carbohydrates within the small intestine * * * Taurocol Compound (Plessner) is indicated in the management of both gastric and intestinal indigestion, especially when associated with chronic cholecystitis.

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LITERATURE & SAMPLES

TAMPONS: Literature describing Tampax, vaginal tampons, points out that they are made of extra-absorptive, long-fibre surgical cotton, so stitched that they cannot disintegrate. Each Tampax has its individual applicator. Both are wrapped together in cellophane. A full-sized package is offered to you free by Tampax, Inc. (ME 12-37), New Brunswick, N. J.

VARICOSE ULCERS: If the foot and leg are bandaged with Tensoplast (elastic adhesive bandage) the patient suffering from varicose ulcers is said to be able to remain at work. According to descriptive literature, the ulcers heal at an average rate of one square inch per week when treated in this manner. A copy of the literature is available from Smith & Nephew, Inc. (ME 12-37), 114 E. 32nd St., New York, N. Y.

BRONCHOSPASTIC CONDITIONS: Ephedrinets make possible the administration of ephedrine by inhalation. They are a non-tobacco cigarette containing ephedrine in the form of an alkaloid in oil, in addition to cubebs. Ephedrinets are prescribed for the effective relief of bronchospastic conditions. You can obtain a free sample from the York Drug Company, Inc. (ME 12-37), 333 Hudson St., New York, N. Y.

ARTHRITIS: A copy of a brand new booklet about Ven-Apis is yours for the asking. Ven-Apis is the biologically standardized venom of the honey bee. Through its use, the literature says, patients suffering from rheumatism, neuralgia, and arthritis show a remarkable increase in the cholesterine level of the blood. Address the R. J. Strasenburgh Company (ME 12-37), 195 Exchange St., Rochester, N. Y.

PIPES AND TOBACCO: Pipe smokers will find this 24-page book intensely interesting. It's the charter catalog issue of *Pipe & Pouch*, America's first smokers' magazine. Among its contents are specially written articles by Hendrik Willem Van Loon, Edward G. Robinson, Christopher Morley, and John Erskine. A postcard addressed to the Pipe and Tobacco Guild, Ltd. (ME 12-37), 79 Madison Ave., New York, N. Y., will bring you a copy.

NAMEPLATES: Your shingle is your personal representative. Does it do you justice? Or is it shabby and illegible? If there's any doubt about it, you had better send for a copy of a catalog of interesting new nameplates available from John M. Doyle (ME 12-37), 17 West 45th St., New York, N. Y.

COUGH: Pertussin, its makers say, provides effective therapy in combating coughs due to respiratory infections, bronchitis, and contagious diseases. Its single ingredient—saccharated extract of thyme—exerts the pharmacodynamic actions necessary for prompt resolution. A generous sample and brochure, "Physiologic and Therapeutic Consideration of

Cough," will be supplied on request. Write to Seeck & Kade, Inc. (ME 12-37), 440 Washington St., New York, N. Y.

COLDS AND SORE THROATS: Kress & Owen (ME 12-37), 361 Pearl St., New York, N. Y., will send a clinical sample of Glyco-Thymoline to any interested physician. This is an alkaline preparation for relieving congestion and inflammation of mucous membrane without irritation. It is said to stimulate local capillary circulation and to help restore normal tone.

ACNE: In treating your next case of acne, the makers of Sulpho-lac (colloidal sulphur cream) suggest you try their product. They'll send you an adequate sample. The preparation is said to correct the two major causes of acne by dissolving the horny deposit from the hyperkeratotic follicle and by checking the hypersecretion of the sebaceous glands. Address Kelgy Laboratories (ME 12-37), 20 W. 22nd St., New York, N. Y.

NUTRITIONAL ANEMIA: Send to the Wisconsin Alumni Research Foundation (ME 12-37), Madison, Wis., for a complimentary copy of "Building Hemoglobin with Iron Plus Copper in Nutritional Anemia." The foundation is in a position to write authoritatively on this relatively new and much discussed form of therapy.

THROAT CONDITIONS: This offer includes a reprint of an article by Dr. E. Markey Pullen, published in *Clinical Medicine and Surgery*, entitled, "O-R-95 in the Treatment of Inflammatory Conditions of the Throat." Accompanying the reprint is a sample of O-R-95, the new anesthetic and antiseptic throat tablet. Write to the Medico Chemical Corp. of America (ME 12-37), 15 E. 40th St., New York, N. Y.

PAIN: A clinical sample of Hyosed is offered by Walker, Corp & Company, Inc. (ME 12-37), Syracuse, N. Y. This product is indicated to blunt pain, to quiet excited nerves, and to produce sleep even though pain is present. It is a combination of phenyl-ethyl-malonyl-urea, dimethyl-amino-antipyrine, and hyoscyamus extract, in a lactose sucrose base. Your free trial supply will be mailed promptly upon request.

OFFICE FURNITURE: Facts about a furniture budget plan, together with descriptions and illustrations of the numerous styles of Allison's office furniture, are incorporated in an attractive catalog put out by the W. D. Allison Company (ME 12-37), 1123 Burdsal Parkway, Indianapolis, Ind. Your request will be answered promptly.

TOPICAL ANODYNE: According to the manufacturers of Bet-U-Lol, it fulfills all professional requirements for quick, safe, and potent analgesic action in cases of muscle, joint, or nerve inflammation. Because it is applied externally, literature points out that the preparation can not provoke gastric, renal, or cardiac disturbance, and it will not blister. A liberal clinical supply is yours for the asking. Address Huxley Laboratories, Inc. (ME 12-37), 160 E. 56th St., New York, N. Y.

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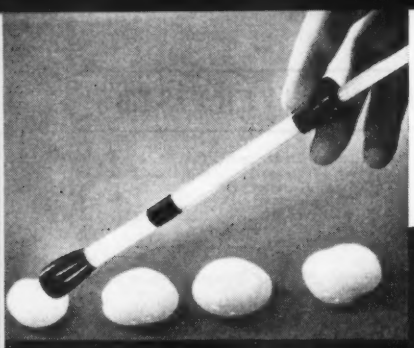

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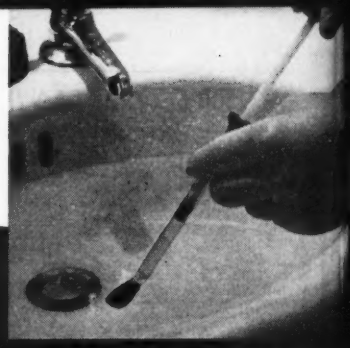

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